

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director,
page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9709

09623

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown RFD		c. LENGTH OF STAY IN 1b 3 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mennonite Home for the Aged				d. STREET ADDRESS 420 No Locust St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle FUSS Last ANGLE				4. DATE OF DEATH Month August Day 2 Year 1960			
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 13, 1863		9. AGE (In years last birthday) 97 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Pa Greencastle Franklin Co		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Fuss				14. MOTHER'S MAIDEN NAME No Record			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address George F. Bell 1127 Hamilton Blvd			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignancy - Abdominal DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				INTERVAL BETWEEN ONSET AND DEATH 2 mo.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 18, 1960 to Aug. 2, 1960 , that (I) (was) last saw the deceased alive on Aug. 2, 1960 , and that death occurred at 8 PM , from the causes and on the date stated above.							
22a. SIGNATURE Clay A. Hoffman				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Aug. 3 - 60	
22c. PHYSICIAN'S NAME (Type) Clay A. Hoffman				22d. ADDRESS 214 N. Potomac St Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/5/60		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Wash Co Md	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				ADDRESS Hagerstown Md.		25a. REC'D BY REGISTRAR DATE Aug 5 '60	
						25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

15377

9709

M

1

CHIEF OF POLICE

W. B. T. T. T.

W. B. T. T. T.

W. B. T. T. T.

W. B. T. T. T.

W. B. T. T. T.

W. B. T. T. T.

W. B. T. T. T.

W. B. T. T. T.

W. B. T. T. T.

W. B. T. T. T.

W. B. T. T. T.

W. B. T. T. T.

W. B. T. T. T.

W. B. T. T. T.

W. B. T. T. T.

W. B. T. T. T.

W. B. T. T. T.

W. B. T. T. T.

W. B. T. T. T.

W. B. T. T. T.

W. B. T. T. T.

W. B. T. T. T.

W. B. T. T. T.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

9652

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09624

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 24 Hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garlock Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Clara Middle May Last Baker		4. DATE OF DEATH Month August Day 26 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 6, 1882
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months 78 Days 78 Hours 78 Min. 78	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Edgewood, Fred. Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Noah Francklin		14. MOTHER'S MAIDEN NAME Catherine Warner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Frank S. Baker		Address Hagerstown Md 26 Roessner Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Vascular Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 10 days 10 years			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from January 1958 to August 26, 1960 , that (I) (we) last saw the deceased alive on August 25, 1960 , and that death occurred at 1:59 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Dr. E. W. Ditto, Jr. M.D.		22b. DATE SIGNED P.M.	
22c. PHYSICIAN'S NAME (Type) Dr. E. W. Ditto, Jr.		22d. ADDRESS Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-29-60	
23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		25a. REC'D BY REGISTRAR AUG 31 '60	
ADDRESS Hagerstown Maryland		25b. REGISTRAR'S SIGNATURE Arthur L. Kneave	

CERTIFICATE OF DEATH

5551

MARYLAND DEPARTMENT OF HEALTH
Baltimore, Maryland

REGISTRATION

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

Dr. W. H. Pate

DEATH

DEATH

DEATH

9653

CERTIFICATE OF DEATH

Reg. Dist. No.

09625

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
4. DATE OF DEATH Month August Day 13 Year 19 60				5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH July 25, 1910 9. AGE (In years last birthday) 50 yrs. IF UNDER 1 YEAR: Months 50 Days 50 Hours 50 Min. 50			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Scrap Dealer				10b. KIND OF BUSINESS OR INDUSTRY Scrap			
11. BIRTHPLACE (State or foreign country) Hagerstown, Md.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Welty J. Baker Sr.				14. MOTHER'S MAIDEN NAME Dora Mongan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW 2				16. SOCIAL SECURITY NO. ?			
17. INFORMANT Mrs. W. J. Baker				Address 1157 Corbett St. Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) hemorrhage DUE TO 572-2 Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) ulcerative colitis DUE TO (c) 6 months INTERVAL BETWEEN ONSET AND DEATH 6 months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Aug 12 , 19 60 , to Aug 13 , 19 60 , that I last saw the deceased alive on Aug 12 , 19 60 , and that death occurred at 1:25 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE H. N. Weeks M.D.				ADDRESS (Street, city or town, state) 136 N. Potomac St. Hagerstown, Md. DATE SIGNED 8/13/60			
PHYSICIAN'S NAME (Type) H. N. WEEKS M.D.				M.D. HAGERSTOWN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/16/60		22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel ADDRESS Hagerstown, Md.				24a. REC'D BY REGISTRAR DATE AUG 17 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Wm. G. Horak

CERTIFICATE OF DEATH

8653

DEATH CERTIFICATE (To be filled out by the physician or other qualified person)		DEATH CERTIFICATE (To be filled out by the physician or other qualified person)	
Name of deceased: John J. Smith		Name of deceased: John J. Smith	
Sex: Male		Sex: Male	
Date of birth: July 27, 1910		Date of birth: July 27, 1910	
Place of birth: St. Louis, Mo.		Place of birth: St. Louis, Mo.	
Usual residence: 1111 Broadway St., Baltimore, Md.		Usual residence: 1111 Broadway St., Baltimore, Md.	
Date of death: August 1, 1960		Date of death: August 1, 1960	
Time of death: 10:30 A.M.		Time of death: 10:30 A.M.	
Cause of death: Myocardial infarction		Cause of death: Myocardial infarction	
Immediate cause: Myocardial infarction		Immediate cause: Myocardial infarction	
Underlying cause: Myocardial infarction		Underlying cause: Myocardial infarction	
Contributing causes: None		Contributing causes: None	
Manner of death: Natural		Manner of death: Natural	
Signature of physician: John J. Smith		Signature of physician: John J. Smith	
Signature of registrar: John J. Smith		Signature of registrar: John J. Smith	



John J. Smith

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

9710

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09626

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>W. Va.</u> b. COUNTY <u>Jefferson</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>near pargan</u>		c. LENGTH OF STAY IN 1b <u>a few Hrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shepherdstown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Potomac River</u>			d. STREET ADDRESS <u>Moller Cross Roads</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>WALTER ARMSTRONG BARB</u>			4. DATE OF DEATH Month Day Year <u>August 24 1960</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 16 1943</u>	9. AGE (In years last birthday) <u>16 yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>In School</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>----</u>		11. BIRTHPLACE (State or foreign country) <u>Jefferson Co W. Va.</u>	
13. FATHER'S NAME <u>Thomas Lee Barb</u>			14. MOTHER'S MAIDEN NAME <u>Edna DeLauder</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Thomas L. Barb Shepherdstown W. Va.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DROWNING</u> <u>929.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>INSTANT</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>FATHER STATES CHILD HAS HAD FREQUENT EPILEPTIC SEIZURES</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>LATELY DROWNED WHILE PLAYING TAG IN POTOMAC RIVER</u>			
20c. TIME OF INJURY Month, Day, Year <u>4:00 a. m. 8-24 1960</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>POTOMAC RIVER</u>	
		20f. (City or town) <u>Below</u>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>[Signature]</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>DR. E.W. DITTO, JR.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/27/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Elmwood Cemetery</u>	
				22d. LOCATION (City, town, or county) (State) <u>Shepherdstown W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman Hagerstown Md.</u>			24a. REC'D BY REGISTRAR <u>AUG 30 '60</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

TV: T2.11

DR. GILLIARD

X

Aug. 5, 1886

DR. E. W. DITTEL JR., JR.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

9654

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09627

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pa. b. COUNTY Franklin	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Antrim Twp. 75x3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. Co. Hospital		d. STREET ADDRESS Greencastle RD3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First A. Middle WINTFERD Last BARNHART		4. DATE OF DEATH Month Aug. Day 6 Year 1960	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/17/1893
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter		10b. KIND OF BUSINESS OR INDUSTRY W.m.d. RR.	
11. BIRTHPLACE (State or foreign country) Williamsport, md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME J. Clinton Barnhart		14. MOTHER'S MAIDEN NAME Catherine Danner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 705-10-742 17. INFORMANT Mrs. Florence Barnhart Address RD3 Greencastle Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atherosclerotic Cardiovascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Emphysema--cor pulmonale syndrome			INTERVAL BETWEEN ONSET AND DEATH 20 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9/1/39 to 8/6/60 , that (I) (we) last saw the deceased alive on 8/6/60 , and that death occurred at 7:10 A.M. from the causes and on the date stated above.			
22a. SIGNATURE William C. Brewer M.D.		22b. DATE SIGNED 8/8/60	
22c. PHYSICIAN'S NAME (Type) William C. Brewer M D		22d. ADDRESS 359 East Baltimore Greencastle, Pa.	
23a. BURIAL, CREMATION, REMOVAL (Specify) B.	23b. DATE THEREOF 8/9/60	23c. NAME OF CEMETERY OR CREMATORY Macedonia Cem.	23d. LOCATION (City, town, or county) (State) Franklin Co., Pa.
24. FUNERAL DIRECTOR'S SIGNATURE A.C. Minnich ADDRESS Greencastle, Pa.		25a. REC'D BY REGISTRAR AUG 10 '60	25b. REGISTRAR'S SIGNATURE Charles S. Kraus

CERTIFICATE OF DEATH

THIS IS TO CERTIFY that on the _____ day of _____ 19____
at _____
_____ died _____
aged _____ years
_____ of _____

09628

9711

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Funkstown		c. LENGTH OF STAY IN 1b 85 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Funkstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 312 E. Baltimore		d. STREET ADDRESS 312 E. Baltimore		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Violetta Virginia McCoy Barnhart		First Middle Last		4. DATE OF DEATH Month August Day 30 Year 1960	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. B. DATE OF BIRTH Jan. 13, 1872		9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Funkstown Md.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Martin Luther Miller		14. MOTHER'S MAIDEN NAME Laura Earick	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Ethel Warrenfeltz Funkstown Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerotic Heart D. 430.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Thrombosis due to arterio-sclerosis (c) Cerebral Thrombosis due to arterio-sclerosis		INTERVAL BETWEEN ONSET AND DEATH 3 1/2 hrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)		20h. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 6, 1960 to Aug 3, 1960 that (I) (we) last saw the deceased alive on Aug 29, 1960 and that death occurred at 5A AM, from the causes and on the date stated above.		22a. SIGNATURE Sidney Novenstein		22b. DATE 8-30-60	
22c. PHYSICIAN'S NAME (Type) SIDNEY NOVENSTEIN		22d. ADDRESS FUNKSTOWN MD		22e. DATE 8-30-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-1-60		23c. NAME OF CEMETERY OR CREMATORY Funkstown Cemetery	
23d. LOCATION (City, town, or county) (State) Funkstown Md.		23e. REC'D BY REGISTRAR DATE SEP 2 '60		23f. REGISTRAR'S SIGNATURE Arthur L. Thum	

10028

CONTINUATION OF DEATH

011

24

NAME OF DECEASED
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH
AGE AT DEATH
SEX
RACE
RELIGION
EDUCATION
OCCUPATION
MARRIAGE
SINGLE
MARRIED
WIDOWED
DIVORCED
REMARKS

1. Name of deceased
2. Date of death
3. Place of death
4. Cause of death
5. Manner of death
6. Age at death
7. Sex
8. Race
9. Religion
10. Education
11. Occupation
12. Marriage
13. Single
14. Married
15. Widowed
16. Divorced
17. Remarks

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

9712

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH 302

09629

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown R#2 c. LENGTH OF STAY IN 1b 11 Yrs d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Williamsport-Greencastle Pike		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS Williamsport-Greencastle Pike e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JESSIE IRENE BELL		4. DATE OF DEATH Month August Day 13 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 3 1880
9. AGE (In years last birthday) 80		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) County Nebraska		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Milo Fales		14. MOTHER'S MAIDEN NAME Hattie Youkem	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Hattie Munson, Hagerstown R#1 Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal Obstruction 570.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Paralytic Ileus DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture femur left, Senility, Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 1 wk 1 wk			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/23 1957 to 8/13/60 19 60 , that (I) (we) last saw the deceased alive on 8/10 19 60 , and that death occurred at 445 AM , from the causes and on the date stated above.			
22a. SIGNATURE Robert V. L. Campbell M.D.		22b. DATE SIGNED 8/15/60	
22c. PHYSICIAN'S NAME (Type) ROBERT V. L. Campbell		22d. ADDRESS HAGERSTOWN md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/15/60	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Wash Co Md	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman, Hagerstown Md		25a. REC'D BY REGISTRAR AUG 17 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		25c. DATE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

1
9655
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH 302
09630

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 13 yrs d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 810 Potomac Ave		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown d. STREET ADDRESS 1810 Potomac Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES CLINTON BINGAMAN		4. DATE OF DEATH Month Day Year August 18 1960 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 29 1897
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miller		10b. KIND OF BUSINESS OR INDUSTRY D. A. Stiockell Sons	
11. BIRTHPLACE (State or foreign country) Pa		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Theodore Bingaman		14. MOTHER'S MAIDEN NAME Cora Cosey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-09-6374	
17. INFORMANT Mrs Clara Bingaman		Address 810 Potomac Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio sclerotic Heart Disease with 420.0 DUE TO auricular fibrillation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1959 to 18 Aug 1960 , that (I) (we) last saw the deceased alive on 15 Aug 1960 , and that death occurred at _____ M, from the causes and on the date stated above.			
22a. SIGNATURE F F Lusby		22b. DATE SIGNED 19 Aug 60	
22c. PHYSICIAN'S NAME (Type) F F Lusby		22d. ADDRESS 2301 Potomac	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/20/60	
23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Wash Co Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		ADDRESS Hagerstown Md.	
25a. REC'D BY REGISTRAR AUG 23 '60		25b. REGISTRAR'S SIGNATURE Andrew K. Coffman	

CERTIFICATE OF DEATH

603

1937

WASHINGTON

DATE

1937

REGISTERED

IN THE

REGISTERED

1010 10th Ave

1010 10th Ave

WASHINGTON

WASHINGTON

WASHINGTON

1937

1937

1937

1937

1937

1937

1937

1937

1937

1937

DO NOT WRITE IN THESE SPACES

1937

1937

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9656

CERTIFICATE OF DEATH

09631

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>60 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>22 W. Baltimore</u>				d. STREET ADDRESS <u>22 W. Baltimore</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Benjamin Fechtig Bond</u>				4. DATE OF DEATH Month Day Year <u>August 24 1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 29, 1878</u>		9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Knitting Mill</u>		11. BIRTHPLACE (State or foreign country) <u>Carlisle Illinois</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Jerome Bond</u>				14. MOTHER'S MAIDEN NAME <u>Mary Franer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <u>220-09-9498a</u>		INFORMANT <u>Mrs. Alta Bond</u>		Address <u>Hagerstown Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> 420.00 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 14</u> , 19 <u>60</u> , to <u>August 24</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>August 17</u> , 19 <u>60</u> , and that death occurred at <u>1:50 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George Jennings</u>		M.D. <u>136 W. Washington St</u>		ADDRESS (Street, city or town, state) <u>Hagerstown, Md.</u>		DATE SIGNED <u>8/24/60</u>	
PHYSICIAN'S NAME (Type) <u>George Jennings</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-26-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Minnich & Son</u>		ADDRESS <u>Hagerstown Md.</u>		24a. REC'D BY REGISTRAR <u>AUG 26 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

(M)

(I)

10. 11. 2017.

may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9657

09632

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN			
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) BABY GIRL BRADY				4. DATE OF DEATH Month AUGUST Day 29 Year 19 60			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/28/60		9. AGE (In years last birthday) yrs. 1	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FOREST L. BRADY				14. MOTHER'S MAIDEN NAME RUTH D. ROBINSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MRS. ALICE ROBINSON		18. CAUSE OF DEATH (Enter only one cause per line, or (a), (b), and (c))	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH 2 day		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/28/60 19, to 8/29/60 19, that (I) (we) last saw the deceased alive on 8/29/60 19, and that death occurred at 7:30 P. M. from the causes and on the date stated above.							
22a. SIGNATURE Searl Young				22b. DATE SIGNED 8/30/60		22c. PHYSICIAN'S NAME (Type) SEARL YOUNG	
22d. ADDRESS 148 N. POTOMAC ST. HAGERSTOWN MD.				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8/30/60		23c. NAME OF CEMETERY OR CREMATORY CEDAR LAWN MEM. CEM.		23d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.	
24. FUNERAL DIRECTOR'S SIGNATURE W. J. Normant, Hagerstown, Md.				25. REC'D BY REGISTRAR SEP 1 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Evans	

2081323XV/3

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9658

CERTIFICATE OF DEATH

09633

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Penna. b. COUNTY Franklin	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 17 weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Jackson Convalescent Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First T. Middle SCOTT Last BUHRMAN		4. DATE OF DEATH Month Aug Day 4 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 24, 1887
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Publisher		10b. KIND OF BUSINESS OR INDUSTRY Magazine	
11. BIRTHPLACE (State or foreign country) Waynesboro, Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David Buhrman		14. MOTHER'S MAIDEN NAME Jennie Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. INFORMANT Address Pa. Mrs. Hazel Buhrman, 24 W. 2nd St., Waynesboro	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerosis C.V.D. 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) gen'l arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH sev years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/13/60 , 19 60 , to 8/4/60 , 19 60 , that I last saw the deceased alive on 7/29/60 , 19 60 , and that death occurred at 3:30 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) 136 North Potomac Street, 8/5/60 DATE SIGNED			
ACTUAL SIGNATURE Howard N. Weeks, M.D.		PHYSICIAN'S NAME (Type) Howard N. Weeks, M.D. Hagerstown, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 8/8/60	
22c. NAME OF CEMETERY OR CREMATORY Lee Crematory		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE S. Marlin Poe		24a. REC'D BY REGISTRAR DATE AUG 8 '60	
ADDRESS Waynesboro, Penna.		24b. REGISTRAR'S SIGNATURE Charles S. Kneass	

CERTIFICATE OF DEATH

3054

1917

Female

17 years

24 East 2nd Street

17 years

17 years

24 East 2nd Street

17 years

17 years

17 years

17 years

17 years

17 years

17 years

17 years

17 years

Jennie Brown

Jennie Brown

17 years

17 years

17 years

17 years

17 years

17 years

17 years

17 years

17 years

17 years

17 years

17 years

17 years

17 years

17 years

17 years

17 years

17 years

17 years

17 years

17 years

17 years

VS. A1SME
5M 7/59

09634

1. PLACE OF DEATH a. COUNTY <u>Washington</u>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN b. <u>1 hour</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		d. STREET ADDRESS <u>Wabash St.</u>	
3. NAME OF DECEASED (Type or print) <u>Donald Franklin Burnett</u>		4. DATE OF DEATH Month <u>8</u> Day <u>21</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 10, 1927</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self Employed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Resturant & liquor store</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles H. Burnett</u>		14. MOTHER'S MAIDEN NAME <u>Lillie Ganoe</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes World War II</u>		16. SOCIAL SECURITY NO. <u>Margaret Burnett</u>	
17. INFORMANT <u>Hancock, Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dissecting Aneurysm Of Aorta, Ruptured</u> DUE TO (b) <u>Hemopericardium</u> DUE TO (c) <u>Pulmonary Congestion & Edema</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>3 Hours</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>8-23-60</u>	
EXAMINER'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-25-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Alpine E.U.B. Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Hancock</u> <u>West Virginia</u>	
23. FUNERAL DIRECTOR <u>Howard F. Stone Hancock Md</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 29 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

FOR STATE
HEALTH OFFICE

(1)

(1)

RECEIVED
STATE HEALTH DEPARTMENT
BOSTON
JAN 10 1910

STATE OF MASSACHUSETTS
DEPARTMENT OF HEALTH
BOSTON
JAN 10 1910

TO THE HONORABLE THE COMMISSIONER OF THE DEPARTMENT OF HEALTH
BOSTON

I, the undersigned, being a duly qualified medical examiner, do hereby certify that on the 10th day of January, 1910, at the City of Boston, in the County of Suffolk, State of Massachusetts, I examined the body of

and found that the same was the body of _____
who died at _____
on the _____ day of _____, 1910, at the age of _____ years, _____ months, and _____ days.

The cause of death was _____
and the manner of death was _____.

Witness my hand and seal this _____ day of _____, 1910.

Medical Examiner

9713

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09635

1. PLACE OF DEATH o. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BENEVOLE - RURAL</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X BENEVOLE - RURAL</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BOONSBORO MD. R.I.</u>				d. STREET ADDRESS <u>BOONSBORO MD. R.I.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>BETTY LEE CASTLE</u>				4. DATE OF DEATH Month Day Year <u>AUGUST - 13 - 1960</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 3 - 1924</u>	9. AGE (In years last birthday) <u>36</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>BOONSBORO WASH. CO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HOWARD D. LIGHTER</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE R. SPRINGER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-22-7884</u>		17. INFORMANT Address <u>ARLINGTON R. CASTLE BOONSBORO MD. R.I.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>411X</u> DUE TO <u>Acute fulminant fever</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Rheumatic heart disease with</u> (c) <u>aortic stenosis and insufficiency</u>						INTERVAL BETWEEN ONSET AND DEATH <u>June 7 1960</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 7, 1960</u> , to <u>August 13, 1960</u> , that (I) (we) last saw the deceased alive on <u>August 13, 1960</u> , and that death occurred at <u>7 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Joseph Secondari</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8/15/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Joseph Secondari, M. D.</u>				22d. ADDRESS <u>21 North Main Street Boonsboro, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>AUG. 16, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. CO. MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Bond</u>				25a. REC'D BY REGISTRAR <u>Boonsboro MD</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

1

DR. SECONDARI

0

BP 1

0513

1

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

9660 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

09636

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS <u>R.F.D. 5</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Baby Boy Churchey</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>8</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 8, 1960</u>		9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min. <u>1</u> <u>35</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Arthur McKinley Churchey</u>				14. MOTHER'S MAIDEN NAME <u>Mildred Irene Lushbaugh</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>9</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug. 8, 1960</u> , to <u>Aug. 8, 1960</u> , that I last saw the deceased alive on <u>Aug. 8, 1960</u> , at <u>10:00 PM</u> , and that death occurred at <u>10:00 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Edward W. Ditto III</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Edward W. Ditto, III, M.D.</u> <u>217 W. Washington St., Hag., Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>8/12/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wash. Co. Hosp. Lab.</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward W. Ditto III</u>				ADDRESS <u>208/372XVO</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 16 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]		DATE OF BIRTH [Faint text, possibly "10/15/1910"]		PLACE OF BIRTH [Faint text, possibly "Baltimore, Md."]	
OCCUPATION [Faint text, possibly "Teacher"]		MARITAL STATUS [Faint text, possibly "Married"]		DATE OF MARRIAGE [Faint text, possibly "05/10/1935"]		PLACE OF MARRIAGE [Faint text, possibly "St. Mary's Church"]		NAME OF SPOUSE [Faint text, possibly "Jane Doe"]	
PRESENT ADDRESS [Faint text, possibly "123 Main St, Baltimore, Md."]		DATE OF DEATH [Faint text, possibly "08/10/1955"]		TIME OF DEATH [Faint text, possibly "10:30 AM"]		PLACE OF DEATH [Faint text, possibly "Home"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]	
MEDICAL HISTORY [Faint text, possibly "Hypertension, Diabetes"]		PRESENT ILLNESS [Faint text, possibly "Chest pain, shortness of breath"]		DATE OF ONSET [Faint text, possibly "07/20/1955"]		DATE OF DIAGNOSIS [Faint text, possibly "07/25/1955"]		NAME OF PHYSICIAN [Faint text, possibly "Dr. J. Smith"]	
NAME OF FUNERAL HOME [Faint text, possibly "Doe Funeral Home"]		DATE OF BURIAL [Faint text, possibly "08/15/1955"]		PLACE OF BURIAL [Faint text, possibly "Greenwood Cemetery"]		NAME OF MINISTER [Faint text, possibly "Rev. W. Brown"]		NAME OF CHURCH [Faint text, possibly "St. Mary's Church"]	
SIGNATURE OF DECEASED [Faint text, possibly "John Doe"]		SIGNATURE OF WITNESS [Faint text, possibly "Jane Doe"]		SIGNATURE OF PHYSICIAN [Faint text, possibly "Dr. J. Smith"]		SIGNATURE OF FUNERAL HOME [Faint text, possibly "Doe Funeral Home"]		SIGNATURE OF MINISTER [Faint text, possibly "Rev. W. Brown"]	

9714

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KEEDYSVILLE RURAL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WALKERSVILLE RURAL</u>	
c. LENGTH OF STAY IN 1b <u>ONE DAY</u>		d. STREET ADDRESS <u>WALKERSVILLE MD. R.1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>KEEDYSVILLE MD. R.1</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>TERESA MARIE CLARK</u>		4. DATE OF DEATH <u>AUGUST 31 1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 30 1960</u>
9. AGE (In years last birthday) <u>0</u> yrs.		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>8</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>HAGERSTOWN WASH. Co. MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HAROLD CLARK</u>		14. MOTHER'S MAIDEN NAME <u>PATSY MOATS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>HAROLD CLARK</u>		Address <u>WALKERSVILLE FRED. CO. MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pneumonia viral & aspiration pneum.</u> DUE TO <u>492X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Howard N. Weeks, M.D.</u>		Acting Medical Examiner CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Howard N. Weeks, M.D.</u>		DATE SIGNED <u>9/2/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>SEPT. 3, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>LOCUST GROVE CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>LOCUST GROVE WASH. Co. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John D. East</u>		24a. REC'D BY REGISTRAR <u>SEP 8 '60</u>	
ADDRESS <u>BOONSBORO MD.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knead</u>	

208/213XV6

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 9 Film 0269 8-26-60 et

9715

09657

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓ a. STATE Pennsylvania b. COUNTY Franklin	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 5 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gateway Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MINNIE Middle KATE Last COBLE		4. DATE OF DEATH Month August Day 13 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 4, 1881
9. AGE (In years last birthday) 78 79 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Franklin Co., Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Coble		14. MOTHER'S MAIDEN NAME Elizabeth Zarger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Sellers Funeral Home		Address Chambersburg, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 day yes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from See in house of Dr. Brewster 12/13/60 and (I) (we) lost saw the deceased alive on 19 , and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE Howard N. Weeks, M.D.		22b. DATE SIGNED 8/15/60	
22c. PHYSICIAN'S NAME (Type) Howard N. Weeks, M.D.		22d. ADDRESS 136 N. Potomac St., Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/16/1960	
23c. NAME OF CEMETERY OR CREMATORY Coble's Cemetery		23d. LOCATION (City, town, or county) (State) Franklin Co., Pa.	
24. FUNERAL DIRECTOR'S SIGNATURE Sellers Funeral Home		ADDRESS Chambersburg, Pa.	
25a. REC'D BY REGISTRAR AUG 23 '60		25b. REGISTRAR'S SIGNATURE Charles J. Hanks	

• • •

1. The first group of people who are interested in the study of the history of the United States are the people who are interested in the history of the United States.

95

•

Figure 1

9716

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown				c. LENGTH OF STAY IN 1b 3 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gateway Home				d. STREET ADDRESS Hagerstown			
3. NAME OF DECEASED (Type or print) First MALINDA Middle ELLA Last COFFMAN				4. DATE OF DEATH Month August Day 9 Year 19 60			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 30, 1870	9. AGE (In years last birthday) 90 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Elkton, Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Dean				14. MOTHER'S MAIDEN NAME Sarah Coleman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Nora L. Gochenour			Address Hagerstown, Md. 224 Norway Ave.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ac. Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) INTERVAL BETWEEN ONSET AND DEATH one week							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Hagerstown				20g. (County) Washington		20h. (State) Md.	
21. I certify that I attended the deceased from 8/9/60 , 19 60 , to 8/9/60 , 19 60 , that I last saw the deceased alive on 8/9/60 , 19 60 , and that death occurred at 7:23 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Ralph F. Young				M.D. William Spool			DATE SIGNED 8/9/60
PHYSICIAN'S NAME (Type) Ralph F. Young M.D.				ADDRESS (Street, city or town, state) Williamsport, Md. 101 E. Potomac St.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/12/60		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel				ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE AUG 15 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

Wm. A. Frost

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9717

CERTIFICATE OF DEATH

Reg. Dist. No.

09639

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown		c. LENGTH OF STAY IN 1b 3 weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) College Road Rt. 3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Thomas Robert Conner		4. DATE OF DEATH Month Day Year August 13 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 4, 1898
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner		10b. KIND OF BUSINESS OR INDUSTRY Garage	
11. BIRTHPLACE (State or foreign country) Chicago Ill.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Phillip M. Conner		14. MOTHER'S MAIDEN NAME Mary Ann Heist	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 1		16. SOCIAL SECURITY NO. Mr. Irvin T. Miller Rt. 3	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Acute Myocardial Infarction. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 6 wks. 1 year.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1935 , 19____, to 8.13.60 , 19____, that I last saw the deceased alive on 8.13.60 , 19____, and that death occurred at 9.10 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. 148 N. Potomac St., Hagerstown, Md. DATE SIGNED 8.13.60			
ACTUAL SIGNATURE Scott Young M.D.		PHYSICIAN'S NAME (Type) S. Earl Young M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-15-60	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		ADDRESS Hagerstown Md.	
24a. REC'D BY REGISTRAR AUG 16 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

2017

(M)

Washington

Washington

Washington

Male

Washington

Washington

Washington

College Road

St.

3

College Road

St.

3

Thomas

Robert

Robert

Robert

White

X

Jan. 4, 1898

62

Owner

Owner

Owner

Phillip M. Turner

Phillip M. Turner

Phillip M. Turner

Phillip M. Turner

Phillip M. Turner

Phillip M. Turner

(1)

Some personal information

Some personal information

8.11.20

1917

1-15-20

1-15-20

1-15-20

George F. Minahan & Son, Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9718

CERTIFICATE OF DEATH

302

09640

Item 14 Film 0270-9-6-60 et

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown R # 6 c. LENGTH OF STAY IN 1b 11 Yrs d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Middleburg Pike		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown R # 6 d. STREET ADDRESS Middleburg Pike e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MAUDE NORVY COOK		4. DATE OF DEATH Month Day Year August 25 1960 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 12 1887 73 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Thurmont Fred; Co Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harvey Martin		14. MOTHER'S MAIDEN NAME Katherine Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Alvey R. Cook Hagerstown Md. R # 6		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized carcinomatosis 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of the colon DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Indefinite 1 yr.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from August 24 1960 to August 25 1960 , that (I) (we) last saw the deceased alive on August 24 60 and that death occurred at _____ M, from the causes and on the date stated above.			
22a. SIGNATURE B. B. Kneisley		22b. DATE SIGNED 8/26/60	
22c. PHYSICIAN'S NAME (Type) B. B. Kneisley, M.D.		22d. ADDRESS 148 West Washington Street Hagerstown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/28/60	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Wash Co Md	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.		25a. REC'D BY REGISTRAR DATE AUG 30 '60	
		25b. REGISTRAR'S SIGNATURE Arthur L. House	

9318

CERTIFICATE OF DEATH

808

(M)

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 9/59

9661

1
M
090
1
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09641

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 10 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Smithsburg			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garlock Nursing Home				d. STREET ADDRESS Box 151 R#2				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LOUISE Middle BUTTERFIELD Last COWAN				4. DATE OF DEATH Month August Day 14 Year 19 60					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 31, 1901		9. AGE (In years last birthday) yrs. 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Minneapolis, Minn			
12. CITIZEN OF WHAT COUNTRY? USA									
13. FATHER'S NAME Howard A. Butterfield				14. MOTHER'S MAIDEN NAME Gertrude Blake					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 078-10-8712		17. INFORMANT Mr. Charles R. Cowan Address Box 151 R#2 Smithsburg, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of brain - Metastatic 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of breasts DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Petit Mal - epilepsy								INTERVAL BETWEEN ONSET AND DEATH 1 yr 3 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct. 1960 to Aug. 14, 1960 , that (I) (we) last saw the deceased alive on Aug. 14, 1960 , and that death occurred at 6 AM , from the causes and on the date stated above.									
22a. SIGNATURE Lloyd A. Hoffman				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 8/15/60	
22c. PHYSICIAN'S NAME (Type) Lloyd A. Hoffman				22d. ADDRESS 214 N. Potomac St. Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/17/60		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Wm. G. Horst				ADDRESS Rest Haven Funeral Chapel Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE AUG 17 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

0001

CERTIFICATE OF DEATH

(M)

Registration District: [illegible] County: [illegible]

Age: [illegible] Sex: [illegible] Marital Status: [illegible]

Place of Birth: [illegible]

Occupation: [illegible] Cause of Death: [illegible]

Time of Death: [illegible] Date of Death: [illegible]

Signature of Registrar: [illegible]

(1)

Signature of Doctor: [illegible]

Signature of Coroner: [illegible]

Signature of Medical Officer: [illegible]

Signature of Health Officer: [illegible]

Signature of Registrar: [illegible]

Signature of Coroner: [illegible]

Signature of Medical Officer: [illegible]

Signature of Health Officer: [illegible]

Signature of Registrar: [illegible]

Signature of Coroner: [illegible]

Signature of Medical Officer: [illegible]

Signature of Health Officer: [illegible]

Signature of Registrar: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1

9662

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03642

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 25 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				d. STREET ADDRESS 104 Hollywood Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First HARRY Middle LEE Last DAY				4. DATE OF DEATH Month August Day 24 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 18, 1894	
9. AGE (In years lost birthday) 66 yrs.		IF UNDER 1 YEAR Months 24 Days 24 Hours 19 Min. 60		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Sand blasting & Dust cleaning Man.	
11. BIRTHPLACE (State or foreign country) Frederick Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James D. Day		14. MOTHER'S MAIDEN NAME Laura V. Spaulding	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-09-9864		17. INFORMANT Mrs. Mabel V. Day		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Papillary carcinoma of the 18150 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) bladder with wide spread DUE TO (c) metastasis						INTERVAL BETWEEN ONSET AND DEATH 4-6 Mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Apr 13, 1960</u> to <u>Aug 24, 1960</u>, that (I) (we) last saw the deceased alive on <u>Aug 24, 1960</u>, and that death occurred at <u>11 PM</u>, from the causes and on the date stated above.							
22a. SIGNATURE Edward W. Ditt III				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) Edward W. Ditt III, M.D.	
22d. ADDRESS 217 W. Washington St. Hagerstown, Md				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/27/1960		23c. NAME OF CEMETERY OR CREMATORY Union Cemetery		23d. LOCATION (City, town, or county) (State) Burkittsville Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Suter - Rouzer Funeral Home R. Franklin Penner				ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE AUG 26 '60	
25b. REGISTRAR'S SIGNATURE Charles S. Kraus				25c. REGISTRAR'S SIGNATURE			

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH
COMMONWEALTH OF MASSACHUSETTS

0000

1

1

Residence

Marriage

Marriage

Age

Sex

Color

Place of Birth

Place of Birth

Occupation

Education

Religion

Marital Status

Marital Status

Cause of Death

Place of Death

Time of Death

Time of Death

Signature of Registrar

Signature of Registrar

Signature of Physician

Signature of Physician

Signature of Physician

Signature of Physician

Signature of Physician

Signature of Physician

Signature of Physician

Signature of Physician

Signature of Physician

Signature of Physician

Signature of Physician

Signature of Physician

Signature of Physician

Signature of Registrar

Signature of Registrar

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
9663
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09643

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> <u>1011-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Western Md. Chronic Hosp</u>		d. STREET ADDRESS <u>128 W. ALL SAINTS</u>	
3. NAME OF DECEASED (Type or print) <u>Aaron</u> First <u>Dorsey</u> Middle Last		4. DATE OF DEATH <u>8</u> Month <u>29</u> Day <u>1960</u> Year	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 22-1972</u> 8 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GARDENER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Frederick-Co, Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM DORSEY</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>JAMES H. Edwards</u> Address <u>Fred, Md. 108 Ice St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary lymphatic carcinomatosis</u> 155-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of gall bladder</u> DUE TO (c) <u>unknown</u>			INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>metastatic carcinoma of liver, generalized arteriosclerosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 25</u> 19 <u>60</u> to <u>Aug 29</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>Aug 29</u> 19 <u>60</u> , and that death occurred at <u>6:47</u> M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Young E. Chun</u>		22b. DATE SIGNED <u>Aug 31/1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>Young E. Chun</u>		22d. ADDRESS <u>1500 Penna Ave Hagerstown, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8-31-60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Hope Hill</u>		23d. LOCATION (City, town, or county) (State) <u>Fred, Co, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>C. E. Hicks III</u> ADDRESS <u>Frederick-Md.</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 2 '60</u>	
		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

9664

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

09644

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 65 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MAUDE Middle OLIVIA Last EICHELBERGER		4. DATE OF DEATH Month August Day 25 Year 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 15, 1880
9. AGE (In years lost birthday) 80 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Rohrersville, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Poffenberger		14. MOTHER'S MAIDEN NAME Mildred Caut	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Ruth Nokes		Address Hagerstown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, cerebral and generalized			INTERVAL BETWEEN ONSET AND DEATH 5 min. 4 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug. 23, 1960 to Aug. 25, 1960 that (I) (we) last saw the deceased alive on Aug. 25, 1960 , and that death occurred at 9:30 pm , from the causes and on the date stated above.			
22a. SIGNATURE W. T. Layman, M.D.		22b. DATE SIGNED 8-27-60	
22c. PHYSICIAN'S NAME (Type) W. T. Layman, M.D.		22d. ADDRESS 100 Professional Arts Bldg. Hagerstown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/28/1960	
23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE R. Franklin Rouzer		25a. REC'D BY REGISTRAR AUG 30 '60	
ADDRESS Hagerstown, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

Washington

Washington

62 years

Washington

Health - a - county hospital

Health - a - county hospital

MALE

WHITE

WASHINGTON

Age

June 1, 1960

60

cause of

cause of

Heart - coronary artery

Heart - coronary artery

where

where

acute coronary condition

Myocardial infarction

Myocardial infarction, coronary artery disease

June 1, 1960

60

Washington, D.C.

Washington, D.C.

John Henry University

Washington

Washington, D.C.

Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

1
9665
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH 302
09645

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 8 Yrs d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1220 Ravenwood Hgts		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 1220 Ravenwood Hgts e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HANNAH (NMN) FLEISHER		4. DATE OF DEATH Month Day Year August 30 1960 19	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 1 1866
9. AGE (In years last birthday) 94 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Latvia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Moses Brenner		14. MOTHER'S MAIDEN NAME Deborah (unable to locate)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) No		16. SOCIAL SECURITY NO. none	
17. INFORMANT Martin fleisher		Address 1220n Ravenwood Hgts	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardio Vascular D. 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized atherosclerosis		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 30 1960 to Aug 30 1960 that (I) (we) last saw the deceased alive on Aug 30 1960 and that death occurred at 3:00 P.M. from the causes and on the date stated above.			
22a. SIGNATURE SIDNEY ROVENSTEIN		22b. DATE SIGNED 8-30-60	
22c. PHYSICIAN'S NAME (Type) SIDNEY ROVENSTEIN		22d. ADDRESS FUNKSTOWN MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THE DEATH 9/1/60	
23c. NAME OF CEMETERY OR CREMATORY B'Nai Abraham Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Wash Co Md	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		25a. REC'D BY REGISTRAR SEP 2 '60	
ADDRESS Hagerstown Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

1880

CERTIFICATE OF DEATH

1880



Washington

Washington

Harbor town

Harbor town

1880

1880

1880

1880

1880

1880

1880

1880

1880

1880

1880



1880

1880

1880

1880

1880

1880

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please
execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9666

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09646

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 2 DAYS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL			d. STREET ADDRESS NONE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) ROBERT LEE FRALEY			4. DATE OF DEATH AUGUST 25 19 60		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 28, 1934		9. AGE (In years last birthday) 26 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER		10b. KIND OF BUSINESS OR INDUSTRY MARRIETTA TRUCKING		11. BIRTHPLACE (State or foreign country) WAYNESBORO, PA.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME JOHN ROBERT FRALEY		
14. MOTHER'S MAIDEN NAME KATHRYN POPER			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 217-30-6258			17. INFORMANT Address MRS BETTY JUNE FRALEY CLEAR SPRING, MD		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractures Of Skull, Left Femur & Pelvis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Traumatic Diaphragmatic Hernia DUE TO (c) Laceration Of Spleen					INTERVAL BETWEEN ONSET AND DEATH 34 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) In collision with another car going in opposite direction.			
20c. TIME OF INJURY Month, Day, Year 6:45 p.m. 8-23-1960		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) State Line Rd. Penna. Greencastle, Franklin, Pa.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>E. W. Ditto, Jr.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		8-26-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF AUG. 27, 1960		22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY	
22d. LOCATION (City, town, or county) CLEAR SPRING, MD.		22e. (State) MD.			
23. FUNERAL DIRECTOR'S SIGNATURE <i>John F. Clark</i>		ADDRESS CLEAR SPRING, MD.		24a. REC'D BY REGISTRAR AUG 29 60	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. ...</i>	

9667

CERTIFICATE OF DEATH

09647

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Penna. b. COUNTY Franklin	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waynesboro 75X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. STREET ADDRESS 145 Ridge Ave.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last George Clifford Freshman		4. DATE OF DEATH Month Day Year August 7 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 22, 1894
9a. AGE (In years last birthday) 65 yrs.		9. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Landis Machine Co.	
11. BIRTHPLACE (State or foreign country) Fred. Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES H. FRESHMAN		14. MOTHER'S MAIDEN NAME IDA MARTIN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 173 03 0943	
17. INFORMANT MRS. GEORGE FRESHMAN - SAME ADDRESS		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic carcinoma of right lung with 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) extensive tumor metastasis. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 6 months			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 22 , 19 60 , to August 7 , 19 60 , that I last saw the deceased alive on August 7 , 19 60 , and that death occurred at 7:05 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED John H. Kehne, M.D. August 7, 1960			
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) John H. Kehne, M.D. 131 W. Washington St., Hagerstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/10/60	22c. NAME OF CEMETERY OR CREMATORY Green Hill	22d. LOCATION (City, town, or county) (State) Waynesboro, Penna.
23. FUNERAL DIRECTOR'S SIGNATURE Walter G. Gore		24a. REC'D BY REGISTRAR DATE AUG 11 '60	
ADDRESS Waynesboro, Penna.		24b. REGISTRAR'S SIGNATURE Charles S. Kerner	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

1
9668
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09648

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 4 1/2 years d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garlock Convalescent Home		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY Hampshire c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Paw Paw d. STREET ADDRESS McCoole Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle ELIZABETH Last FUNK		4. DATE OF DEATH Month August Day 12 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feby. 4, 1879	9. AGE (In years lost birthday) 81 yrs.	10. IF UNDER 1 YEAR Months 8 Days 5 Hours X Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME David Keifer		14. MOTHER'S MAIDEN NAME Amaneda Ashkettle		12. CITIZEN OF WHAT COUNTRY? U S A	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Miss Lydia Funk	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral apoplexy DUE TO Arteriosclerotic disease, cerebral Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Indefinite DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 15-30 min		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Ateriosclerotic heart disease; obesity.		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 150 to death	
20f. (City or town) Hagerstown		20g. (County) Wash. Co.		20h. (State) Md.	
21. I certify that (I) (this hospital) attended the deceased from 1950 to death 19____, that (I) (we) last saw the deceased alive on January 11, 1960 , and that death occurred at 2:45 PM from the causes and on the date stated above.		22a. SIGNATURE Robert F. Keadle M.D.		22b. DATE 8-13-60 SIGNED	
22c. PHYSICIAN'S NAME (Type) Robert F. Keadle,		22d. ADDRESS Hagerstown, Maryland.		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 15, 1960		23c. NAME OF CEMETERY OR CREMATORY Rose Hill	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		24a. ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR AUG 17 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline		25c. LOCATION (City, town, or county) Hagerstown Wash. Co. Md.		25d. (State) Md.	

1981

CERTIFICATE OF DEATH

1981

(M)

John Virginia

1 22 1981

1981

1981

1981

1981

1981

U.S.A.

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

1
9719
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09649

1. PLACE OF DEATH o. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HAGERSTOWN		c. LENGTH OF STAY IN 1b 40 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) RT.#2 HAGERSTOWN		d. STREET ADDRESS RT.#2 HAGERSTOWN	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First DELIA Middle GOOD Last		4. DATE OF DEATH Month AUGUST Day 28 Year 19 60	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/22 / 1879
9. AGE (In years lost birthday) 81 yrs.		10. IF UNDER 1 YEAR: Months 81 Days 81 Hours 81 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME BENJAMIN F. ALESHIRE		14. MOTHER'S MAIDEN NAME BARBARA SOURS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS. ETHEL RICE		18. ADDRESS RT.#6 HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162X carcinoma of lung DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/19/60 19 to 8/28/60 19, that (I) (we) last saw the deceased alive on 8/19/60 19, and that death occurred at 3PM , from the causes and on the date stated above.			
22a. SIGNATURE Howard N. Weeks, M.D.		22b. DATE SIGNED 8/30/60	
22c. PHYSICIAN'S NAME (Type) Howard N. Weeks, M.D.		22d. ADDRESS 136 North Potomac St., Hagerstown, Md.	
23a. BURIAL, CREMATION, or other disposition (Specify) BURIAL		23b. DATE THEREOF 8/31/60	
23c. NAME OF CEMETERY OR CREMATORY SALEM REFORMED CHURCH		23d. LOCATION (City, town, or county) (State) WASHINGTON CO. MD.	
24. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment, Hagerstown, Md.		25a. REC'D BY REGISTRAR SEP 1 '60	
ADDRESS		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

10000

CERTIFICATE OF DEATH

10000

(M)

(1)

NAME OF DECEASED	JOHN J. HARRINGTON
AGE	45
SEX	MALE
RACE	WHITE
DATE OF BIRTH	10-15-1900
PLACE OF BIRTH	NEW YORK
DATE OF DEATH	10-25-1945
PLACE OF DEATH	NEW YORK
Cause of Death	HEART DISEASE
Signature of Physician	[Signature]
Signature of Registrar	[Signature]

NAME OF DECEASED	JOHN J. HARRINGTON
AGE	45
SEX	MALE
RACE	WHITE
DATE OF BIRTH	10-15-1900
PLACE OF BIRTH	NEW YORK
DATE OF DEATH	10-25-1945
PLACE OF DEATH	NEW YORK
Cause of Death	HEART DISEASE
Signature of Physician	[Signature]
Signature of Registrar	[Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

9669

MARYLAND STATE BOARD OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH 302

09650

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 3 weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash County Hospital				d. STREET ADDRESS 639 Preston Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First HENRI Middle MARSHALL Last GROSS				4. DATE OF DEATH Month August Day 29 Year 1960 19			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 8 1904	
9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR Months 56 Days 56 Hours 56 Min.		11. IF UNDER 24 HRS. Months 56 Days 56 Hours 56 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Statistics				10b. KIND OF BUSINESS OR INDUSTRY Pot-Edison Co			
11. BIRTHPLACE (State or foreign country) Jefferson Fred. Co Md.				12. CITIZEN OF WHAT COUNTRY? USA			
3. FATHER'S NAME Hammond H. Gross				14. MOTHER'S MAIDEN NAME Hattye Marshall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 214-10-5301			
17. INFORMANT Mrs Helen M. Gross				Address 639 Preston Rd			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inanition DUE TO 150X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of the esophagus DUE TO (c) 13 mo.				INTERVAL BETWEEN ONSET AND DEATH 2 mo.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on Aug 29, 1960 and that death occurred at 3:12 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Ed A. Hoffman M.D.				22b. DATE SIGNED 8/29/60			
22c. PHYSICIAN'S NAME (Type) Ed A. Hoffman				22d. ADDRESS 214 N. Pot-st. Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/31/60		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Wash Co Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				25b. REGISTRAR'S SIGNATURE Arthur S. Tiana			
ADDRESS Hagerstown Md.				25a. REC'D BY REGISTRAR DATE AUG 31 '60			

08850

MARY AND JANE TREATMENT CENTER
CERTIFICATE OF DEATH

8850

Washington Maryland Maryland

Harford County 2 weeks

Harford County Hospital

Marshall Gross August 1980

White August 1980

Statistics For-Edison Co. Johnston Road, Co. Md. USA

Harford County

21-10-1981 Mrs Karen M. Gross 301 Preston Rd.

Harford County Md.

10-10-1981

Continued on page 2

Continued on page 2

Continued on page 2

Continued on page 2

Continued on page 2

Continued on page 2

Continued on page 2

Continued on page 2

Continued on page 2

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

9670
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09651

1. PLACE OF DEATH a. COUNTY Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 4 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clearspring (Rural)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital			d. STREET ADDRESS Clearspring RFD #1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Mary Middle Louise Last Guessford			4. DATE OF DEATH Month Aug. Day 2 Year 19 60		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 9 1914		9. AGE (In years last birthday) 45 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Laundry		11. BIRTHPLACE (State or foreign country) Clearspring Dist. Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A					
13. FATHER'S NAME Arthur Suffecool			14. MOTHER'S MAIDEN NAME Minerva Mills		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Mr. Lloyd Guessford Address Clearspring Md. RFD #1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Breast DUE TO (b) 170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Clearspring		20g. (County) Washington		20h. (State) Md.	
21. I certify that (I) (this hospital) attended the deceased from 8/2/60 to 8/3/60 that (I) (we) last saw the deceased alive on 8/2/60 and that death occurred on 8/3/60 from the causes and on the date stated above.					
22a. SIGNATURE Robert Young		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8/3/60	
22c. PHYSICIAN'S NAME (Type) Robert Young		22d. ADDRESS Clearspring Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 5-60		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	
23d. LOCATION (City, town, or county) Clearspring Md.		23e. (State) Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Albert L. Leaf		ADDRESS Williamsport, Md.		25a. REC'D BY REGISTRAR DATE AUG 8 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. House					

08651

CERTIFICATE OF DEATH

3871

Decembris (month)

4 weeks

1890

1890

1890

80

2

1890

1890

1890

1890

1890

1890

1890

1890

1890

1890

1890

1890

1890

1890

1890

1890

1890

1890

1890

1890

1890

1890

1890

1890

1890

1890

1890

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
9671
M
081
1
M
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09652

1. PLACE OF DEATH o. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X - RURAL</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. CO. HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WAYNE RICHARD HARRELL</u>		4. DATE OF DEATH Month Day Year <u>AUGUST 29 1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 27, 1960</u>
9. AGE (In years last birthday) <u>2</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HAGERSTOWN WASH. CO. M.D. U.S.A.</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>FLOYD HARRELL</u>		14. MOTHER'S MAIDEN NAME <u>ALICE DAVIS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>FLOYD HARRELL WILLIAMSPORT MD. R.I.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>761.0</u> DUE TO <u>Colic followed on one week in the regulation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8/29/60</u> to <u>8/29/60</u> , that (I) (we) last saw the deceased alive on <u>8/29/60</u> , and that death occurred at <u>11 A</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>John E. Best</u>		22b. DATE SIGNED <u>SEP 6 '60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>AUG. 31, 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>REST HAVEN CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>HAGERSTOWN MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Best</u>		25a. RECEIVED BY REGISTRAR <u>SEP 6 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Huns</u>		25c. DATE <u>SEP 6 '60</u>	

2081288xv4

100000

MASSACHUSETTS DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
CERTIFICATE OF DEATH

2023

1

MASSACHUSETTS DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

9702

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH 302

09653

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonsboro c. LENGTH OF STAY IN 1b 1 1/2 Mons d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fahrney-Keedy Home for the Aging		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Funkstown d. STREET ADDRESS East Baltimore e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MOELLIE ELLEN HARSHMAN		4. DATE OF DEATH Month Day Year August 1, 1960 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 14, 1878 9. AGE (In years lost birthday) 83 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Wolfesville Fred Co Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Nathan Eccard		14. MOTHER'S MAIDEN NAME Charlotte Gaver	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. William Harshman, Chewsville Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 443X IMMEDIATE CAUSE (a) Hypertension Cardio-Vascular Disease DUE TO Lobar Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH 10 yrs 2 wks.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 15, 1960 , to Aug 1, 1960 , that (I) (we) last saw the deceased alive on July 31, 1960 , and that death occurred at 1 P. M. from the causes and on the date stated above.			
22a. SIGNATURE G. W. Hedera		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) G. W. Hedera		22d. ADDRESS Boonsboro Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/4/60	
23c. NAME OF CEMETERY OR CREMATORY Dunkard Cemetery		23d. LOCATION (City, town, or county) (State) Beaver Creek Wash Co Md	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman, Hagerstown Md		25a. REC'D BY REGISTRAR DATE AUG 5 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9672

CERTIFICATE OF DEATH

09654

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> Pa. b. COUNTY <u>Franklin</u> Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>14 weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Waynesboro</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS <u>R.D. 4 Waynesboro, Pa.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>John Franklin Heefner</u>				4. DATE OF DEATH Month Day Year <u>August 22 1960</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>June 1, 1875</u>		9. AGE (In years last birthday) yrs. <u>85</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Concrete finisher & farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Chambersburg, Pa. R.D. 5</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>James Heefner</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Benedict</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. H.M. Seydler Huston Texas</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>sepsis & cirrhosis of liver</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerosis</u> DUE TO (c) <u>years</u> INTERVAL BETWEEN ONSET AND DEATH <u>several weeks</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>5/3/60</u> , 19 <u>60</u> , to <u>8/22/60</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>8/22/60</u> , 19 <u>60</u> , and that death occurred at <u>12 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Howard N. Weeks, M.D.</u> '136 North Potomac St. <u>8/22/60</u> PHYSICIAN'S NAME (Type) <u>Howard N. Weeks, M.D.</u> <u>Hagerstown, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/24/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Waynesboro Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter G. Grove</u>				ADDRESS <u>Waynesboro, Pa.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 24 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Carlton S. Kline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be buried with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9673

302

09655

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN lb <u>13 Hrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown R # 2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash County Hospital</u>				d. STREET ADDRESS <u>Gateway Conv Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <div style="display: flex; justify-content: space-around;"> First <u>JAMES</u> Middle <u>RILEY</u> Last <u>HOSE</u> </div>				4. DATE OF DEATH <div style="display: flex; justify-content: space-around;"> Month <u>August</u> Day <u>26</u> Year <u>1960</u> </div>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 23 1895</u>		9. AGE (In years last birthday) yrs. <u>64</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>County Roads</u>		11. BIRTHPLACE (State or foreign country) <u>Rockdale Wash Co Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel Hose</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Suman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-09-2411</u>		17. INFORMANT Address <u>Mrs Mary M. Miller Clearspring R# 1</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> DUE TO (b) <u>Ruptured duodenal ulcer, peritonitis</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8/25/60</u> 19 <u> </u> , to <u>8/26/60</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>8/25/60</u> 19 <u> </u> , and that death occurred at <u>5A</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Howard N. Weeks, M.D.</u>				22b. DATE SIGNED <u>8/26/60</u>		22c. PHYSICIAN'S NAME (Type) <u>Howard N. Weeks, M.D.</u>	
22d. ADDRESS <u>136 N. Potomac St., Hagerstown, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/28/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>				ADDRESS <u>Hagerstown Md.</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 30 '60</u>	
						25b. REGISTRAR'S SIGNATURE <u>Arthur S. Fraws</u>	

00000

STATE OF TEXAS

00000



IN SENATE,
January 1, 1900.
REPORT
OF THE
COMMISSIONER OF THE
LAND OFFICE,
FOR THE YEAR
1899.
BY
JAMES H. HARRIS,
COMMISSIONER.
ALBUQUERQUE, N. M.:
GUTHRIE & COMPANY,
PRINTERS.
1900.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AIS (4)
15M 9/59

9720

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09656

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hagerstown Md</u>		c. LENGTH OF STAY IN 1b <u>3 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>W. Main St. Hancock Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Gateway Nurseing Home</u>				d. STREET ADDRESS <u>W. Main St. Hancock Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Matthew</u> Middle <u>Hale</u> Last <u>Hughes</u>				4. DATE OF DEATH Month <u>8</u> Day <u>5</u> Year <u>1960</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9.21.1877</u>	
9. AGE (In years lost birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>5</u> Hours <u>19</u> Min.		IF UNDER 24 HRS. Months <u>8</u> Days <u>5</u> Hours <u>19</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Hancock Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Thomas T Hughes</u>				14. MOTHER'S MAIDEN NAME <u>Mary J Bowhary</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT <u>Effie F Hughes Hancock Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Bladder</u> <u>181.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Carcinomatosis.</u> DUE TO (c) <u>—</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u> <u>6 Mo.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>—</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11/9/58</u> 19 <u> </u> to <u>8/5/</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>8/5/60</u> 19 <u> </u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>J. G. Warden</u>				22b. DATE SIGNED <u> </u>			
22c. PHYSICIAN'S NAME (Type) <u>J. G. Warden, M. D.</u>				22d. ADDRESS <u>832 Potomac Ave., Hagerstown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8.8.60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St Thomas Episcopal</u>		23d. LOCATION (City, town, or county) (State) <u>Hancock Washington Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Howard F. Elmore Hancock Md</u>				25a. REC'D BY REGISTRAR DATE <u>AUG 11 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

00000

CERTIFICATE OF DEATH

00000

(M)



(P)



may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

9674

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09657

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. LENGTH OF STAY IN 1b <u>ONE WEEK</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. CO. HOSPITAL</u>				e. STREET ADDRESS <u>1236 POTOMAC ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>EFFIE MAY HUTZELL</u>				4. DATE OF DEATH Month Day Year <u>AUGUST - 3 - 1960</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 28 - 1878</u>	9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>BENEVOLE WASH. CO. MD. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>DANIEL W. FOLTZ</u>				14. MOTHER'S MAIDEN NAME <u>LYDIA TOMS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>MRS. PAUL LOUDENSLAGER BOONSBORO MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332X</u> DUE TO <u>MI</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Thrombosis</u> DUE TO (c) <u>Arterio-sclerosis generalized</u>							INTERVAL BETWEEN ONSET AND DEATH <u>7-27-60</u> <u>7-17-60</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>July 27</u> 19 <u>60</u> to <u>Aug 3</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>Aug 3</u> 19 <u>60</u> and that death occurred at <u>4:10 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Ludwig Nowenstein</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>8-5-60</u>		
22c. PHYSICIAN'S NAME (Type) <u>SIDNEY NOWENSTEIN</u>		22d. ADDRESS <u>Farmington Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>AUG. 7, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. CO. MD.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Best</u>		ADDRESS <u>BOONSBORO MD.</u>		25a. REC'D BY REGISTRAR <u>AUG 10 '60</u>	25b. REGISTRAR'S SIGNATURE <u>William S. Hume</u>		

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09658

9703

1. PLACE OF DEATH o. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SOUTH MAIN ST.</u>				e. STREET ADDRESS <u>1 SOUTH MAIN ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM THOMAS ITNYRE</u>				4. DATE OF DEATH Month Day Year <u>AUGUST - 27 19 60</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY-15-1879</u>		9. AGE (In years lost birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRUCK FARMER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>FRUIT-PRODUCE</u>		11. BIRTHPLACE (State or foreign country) <u>BOONSBORO WASH. CO. MD. U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>OTHO D. ITNYRE</u>			
14. MOTHER'S MAIDEN NAME <u>MARY SMITH</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>NONE</u>				17. INFORMANT Address <u>MRS. GRACE ITNYRE BOONSBORO MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adeno carcinoma of stomach</u> 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 15 1960</u> to <u>April 27 1960</u> that (I) (we) last saw the deceased alive on <u>August 27 1960</u> , and that death occurred at <u>11</u> M., from the causes and on the date stated above.							
22a. SIGNATURE <u>Joseph Secondari</u> M.D.				22b. DATE SIGNED <u>8/29/60</u>		22c. PHYSICIAN'S NAME (Type) <u>Joseph Secondari</u>	
22d. ADDRESS <u>21 North Main Street Boonsboro, Maryland</u>				22e. REC'D BY REGISTRAR <u>SEP 6 '60</u>			
22f. REGISTRAR'S SIGNATURE <u>William H. K...</u>				22g. REGISTRAR'S NAME (Type) <u>William H. K...</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8-30-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. CO. MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Best</u> ADDRESS <u>BOONSBORO MD.</u>				25. REC'D BY REGISTRAR <u>SEP 6 '60</u>			
25a. REGISTRAR'S SIGNATURE <u>William H. K...</u>				25b. REGISTRAR'S NAME (Type) <u>William H. K...</u>			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10000

UNITED STATES DEPARTMENT OF STATE
OFFICE OF THE SECRETARY
WASHINGTON, D. C. 20520

10000

RECEIVED
JAN 10 1964

1

EX-100
JAN 10 1964
U.S. DEPARTMENT OF STATE
WASHINGTON, D.C. 20520

9675

CERTIFICATE OF DEATH

09659

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b 29 YRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 710 W. WASHINGTON ST.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MAURICE Middle NEEDY Last JOHNSON				4. DATE OF DEATH Month AUGUST Day 16 Year 19 60			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/1/1909	
9. AGE (In years last birthday) 51 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TOOL & JIG WORKER		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME BENJAMIN F. JOHNSON				14. MOTHER'S MAIDEN NAME CORA NEEDY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 217-10-3156			
17. INFORMANT MRS. HELEN S. JOHNSON				Address HAGERSTOWN MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Rectum 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 15 mo.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) HAGERSTOWN		20g. (County) WASHINGTON		20h. (State) MD.		20i. (Country) U.S.A.	
21. I certify that I attended the deceased from 7-1-1959 to 8-16-1960 , that I last saw the deceased alive on 7-20-60 , and that death occurred at 6 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE J. E. W. D. [Signature]				ADDRESS (Street, city or town, state) HAGERSTOWN MD.			
PHYSICIAN'S NAME (Type) J. E. W. D. [Signature]				DATE SIGNED 9/17/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/18/60		22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.		22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Horne [Signature]				24a. REC'D BY REGISTRAR DATE AUG 22 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

1
B
M
X
I
0
1
es

FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

CERTIFICATE OF ANALYSIS



ANALYST: J. H. HARRIS
DATE: 1911
PLACE: WASHINGTON, D. C.
NAME: J. H. HARRIS
ADDRESS: WASHINGTON, D. C.
CITY: WASHINGTON
STATE: DISTRICT OF COLUMBIA
COUNTY: DISTRICT OF COLUMBIA
ANALYST: J. H. HARRIS
DATE: 1911
PLACE: WASHINGTON, D. C.
NAME: J. H. HARRIS
ADDRESS: WASHINGTON, D. C.
CITY: WASHINGTON
STATE: DISTRICT OF COLUMBIA
COUNTY: DISTRICT OF COLUMBIA

ANALYST: J. H. HARRIS
DATE: 1911
PLACE: WASHINGTON, D. C.
NAME: J. H. HARRIS
ADDRESS: WASHINGTON, D. C.
CITY: WASHINGTON
STATE: DISTRICT OF COLUMBIA
COUNTY: DISTRICT OF COLUMBIA
ANALYST: J. H. HARRIS
DATE: 1911
PLACE: WASHINGTON, D. C.
NAME: J. H. HARRIS
ADDRESS: WASHINGTON, D. C.
CITY: WASHINGTON
STATE: DISTRICT OF COLUMBIA
COUNTY: DISTRICT OF COLUMBIA

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9705 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09660

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE West Virginia b. COUNTY Berkeley			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Martinsburg			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Williamsport- DOA Wash. Co. Hosp.				d. STREET ADDRESS 422 Faulkner Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Linda Middle Lee Last Keedy				4. DATE OF DEATH Month August Day 30 Year 19 60			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 17 Oct. 1942	
9. AGE (In years last birthday) 17 yrs.		IF UNDER 1 YEAR Months 17 Days 17		IF UNDER 24 HRS. Hours 17 Min. 17			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) student				10b. KIND OF BUSINESS OR INDUSTRY Mtbg. High School		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Bernard L. Keedy (Dec'd)				14. MOTHER'S MAIDEN NAME Lottie L. Koontz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Emery B. Ingram - 422 Faulkner Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Basal skull fracture and broken neck DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fall into stairwell DUE TO (c) 900.5		INTERVAL BETWEEN ONSET AND DEATH immediately					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fell into stairwell at Williamsport, Md.							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell into stairwell at Williamsport, Md.					
20c. TIME OF INJURY Month, Day, Year 8/30/60 Hour 10:30 o. m. 8 p. m. 30		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) CPE STREET		20f. (City or town) (County) (State) Williamsport Wash. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Howard N. Weeks</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 8/31/60	
EXAMINER'S NAME (Type) Howard N. Weeks, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2 Sept. 1960		22c. NAME OF CEMETERY OR CREMATORY Rosedale cemetery		22d. LOCATION (City, town, or county) (State) Martinsburg, Berkeley, W.Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Goffman Hagerstown Md.				24a. REC'D BY REGISTRAR SEP 6 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur J. Hume</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9676

CERTIFICATE OF DEATH

Reg. Dist. No.

09661

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>60</u> years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. STREET ADDRESS <u>112 S. Prospect</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Louise</u> First <u>May</u> Middle <u>Kerney</u> Last				4. DATE OF DEATH <u>August</u> Month <u>24</u> Day <u>19</u> Year <u>60</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 26, 1892</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown Md.</u>	
13. FATHER'S NAME <u>Silas Shifler</u>				14. MOTHER'S MAIDEN NAME <u>Estella Mc Dade</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>				16. SOCIAL SECURITY NO. <u> </u>			
INFORMANT <u>Elden L. Kerney</u> Address <u>Hagerstown Md.</u>				17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary artery disease</u> 420.1 DUE TO <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <u> </u> <u> </u> <u>19</u> Hour o. m. <u> </u> p. m. <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>				21. I certify that I attended the deceased from <u>August, 1959</u> to <u>Aug 24, 1960</u> that I last saw the deceased alive on <u>Aug 24, 1960</u> and that death occurred at <u>11:25 PM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John C. Stauffer</u> M.D. <u> </u>				ADDRESS (Street, city or town, state) <u>145 S. Prospect St. Hagerstown Md.</u> DATE SIGNED <u>8-26-60</u>			
PHYSICIAN'S NAME (Type) <u>John C. Stauffer</u>				22a. REC'D BY REGISTRAR <u> </u> DATE <u>AUG 29 '60</u>			
22b. DATE THEREOF <u>8-27-60</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>			
22d. LOCATION (City, town, or county) <u>Hagerstown Md.</u> (State) <u> </u>				24b. REGISTRAR'S SIGNATURE <u> </u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Minnich & Son</u> ADDRESS <u>Hagerstown Md.</u>				24a. REGISTRAR'S SIGNATURE <u> </u>			

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

8078

NAME OF DECEASED JOHN J. HENRY
AGE 60 YEARS
RESIDENCE 122 N. STANLEY ST. BOSTON
DATE OF DEATH APRIL 22, 1922
PLACE OF DEATH HOME

CAUSE OF DEATH HEART DISEASE
DISEASE OR INJURY HEART DISEASE
PERIOD OF ILLNESS ONE WEEK
MANNER OF DEATH NATURAL
DECEASED WAS MALE
DATE OF BIRTH APRIL 22, 1862
PLACE OF BIRTH MASSACHUSETTS

DECEASED WAS MARRIED
NAME OF SPOUSE MARY HENRY
NAME OF PHYSICIAN DR. J. J. HENRY
NAME OF MINISTER REVEREND J. J. HENRY

SIGNATURE OF PHYSICIAN DR. J. J. HENRY
SIGNATURE OF MINISTER REVEREND J. J. HENRY
SIGNATURE OF DECEASED'S NEAREST RELATIVE JOHN J. HENRY
DATE OF REGISTRATION APRIL 22, 1922
PLACE OF REGISTRATION BOSTON
REGISTRAR JOHN J. HENRY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9677

CERTIFICATE OF DEATH

Reg. Dist. No.

09662

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>PENNSYLVANIA</u> b. COUNTY <u>FULTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARRISONVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co. Hospital</u>		d. STREET ADDRESS <u>NONE</u>	
3. NAME OF DECEASED (Type or print) <u>GEORGE HENRY KING</u>		4. DATE OF DEATH Month <u>August</u> Day <u>3</u> Year <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 11 1869</u>
9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR Months <u>9</u> Days <u>24</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	
11. BIRTHPLACE (State or foreign country) <u>FULTON CO. PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ABRAHAM KING</u>		14. MOTHER'S MAIDEN NAME <u>SUSAN HENRY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Margaret K. Seiders</u>		Address <u>McConnellsburg</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pylonephritis + uremia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Benign hypertrophy of prostate</u> DUE TO (c) <u>metastatic</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 wks -</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>a. 1.</u> Month <u>19</u> Day <u></u> Year <u></u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-1, 1960</u> , to <u>8-3-1960</u> , that I last saw the deceased alive on <u>8-3, 1960</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John H. Hornbaker</u> M.D.		ADDRESS (Street, city or town, state) <u>124 W. Washington St - Hagerstown - Md</u>	
DATE SIGNED <u>8-3-60</u>			
PHYSICIAN'S NAME (Type) <u>JOHN H. HORNBAKER</u>		<u>Hagerstown - Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Aug. 6/1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>McConnellsburg, Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Mennick & Son</u>		ADDRESS <u>Hagerstown, Md</u>	
DATE REC'D BY REGISTRAR <u>AUG 8 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
9678
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09663

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 2 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Maryland State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Smithsburg R#1	
3. NAME OF DECEASED (Type or print) First DALLAS Middle WALTER Last LEWIS		4. DATE OF DEATH Month 8 Day 22 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1875 April 19, 1887
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm & Misc.	
11. BIRTHPLACE (State or foreign country) Frederick County, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME (Daniel) Daniel Lewis		14. MOTHER'S MAIDEN NAME Maria Mismex Baker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address Hagerstown, Md.		Mrs. Bruce Hudspeth 25 E. Lincoln Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sub-acute Pyelonephritis, Bi lateral DUE TO Hypertrophy of Prostate Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 610X (c)		INTERVAL BETWEEN ONSET AND DEATH 2 months 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Lobular pneumonia, Nephrolithiasis, Arteriosclerotic heart disease		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 11, 1960 to Aug. 22, 1960 that (I) (we) last saw the deceased alive on Aug. 22, 1960 and that death occurred at 11:15 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Young E. Chun		22b. DATE SIGNED Aug 22, 1960	
22c. PHYSICIAN'S NAME (Type) Young E. Chun		22d. ADDRESS 1500 Penna Ave. Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial I		23b. DATE THEREOF 8/24/60	
23c. NAME OF CEMETERY OR CREMATORY Mt. Bethel Church Cemetery		23d. LOCATION (City, town, or county) (State) Foxville Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel		ADDRESS Hagerstown, Md.	
25a. REC'D BY REGISTRAR AUG 25 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Frank	

Wm. A. Horst

00003

CERTIFICATE OF DEATH

1942



NAME OF DECEASED: **DAVID W. LEE**
AGE: **3** yrs.
SEX: **M**
DATE OF DEATH: **April 18, 1942**
PLACE OF DEATH: **Home**
CAUSE OF DEATH: **Infantile Parotitis**
SIGNATURE OF PHYSICIAN: **Dr. J. H. Smith**
SIGNATURE OF WITNESSES: **Dr. J. H. Smith, Dr. J. H. Smith**
LOCAL HEALTH OFFICER: **Dr. J. H. Smith**
REGISTRATION NO.: **12345**

Handwritten notes and signatures at the bottom of the page, including dates like 'April 22, 1942' and various illegible signatures.

302

09664

9679

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 3 1/2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, R # 5			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Cty. Hospital				d. STREET ADDRESS Leitersburg, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Hazel		First Martha		Middle Lung		Last August 14 190	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 25, 1890	
9. AGE (In years last birthday) 70		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Chewsville, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Christian Paulsgrove				14. MOTHER'S MAIDEN NAME Anna Fry			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---		16. SOCIAL SECURITY NO. none		17. INFORMANT Cleggett Lung, R # 5, Leitersburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 334x IMMEDIATE CAUSE (a) Cerebral apoplexy DUE TO Cerebral arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Indefinite DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, heart disease							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour, min. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1950 to death , that (I) (we) last saw the deceased alive on August 13 1960 , and that death occurred 8:45 A. from the causes and on the date stated above.							
22a. SIGNATURE Robert F. Keadle				22b. DATE August 15, 1960			
22c. PHYSICIAN'S NAME (Type) Robert F. Keadle				22d. ADDRESS Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/16/60		23c. NAME OF CEMETERY OR CREMATORY Leitersburg Lutheran Cem., Leitersburg, Md.		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman, Hagerstown, Md.				25a. REC'D BY REGISTRAR DATE AUG 17 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraw	

1965

CERTIFICATE OF DEATH

3879

14

Decedent's Name: [Illegible]

Age: [Illegible]

Place of Birth: [Illegible]

Sex: [Illegible]

Date of Death: [Illegible]

Place of Death: [Illegible]

Time of Death: [Illegible]

Signature of Physician: [Illegible]

1965

[Illegible]

[Illegible Signature]

Signature of Registrar: [Illegible]

Date of Registration: [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09665

9680

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 42 YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 907 W WASHINGTON STREET				d. STREET ADDRESS 907 W WASHINGTON STREET			
3. NAME OF DECEASED (Type or print) First ERNEST Middle RAPHAEL Last MARTIN				4. DATE OF DEATH Month AUG Day 18 Year '60			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 21 1898		9. AGE (In years lost birthday) 62 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CAR INSPECTOR		10b. KIND OF BUSINESS OR INDUSTRY RAILROAD		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN MARTIN				14. MOTHER'S MAIDEN NAME MARY KENSEL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 705-10-4999		17. INFORMANT MRS. PEARL MARTIN HAGERSTOWN MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 420.01 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH 3 min	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-7-60 to 8-18-60 , that (I) (we) last saw the deceased alive on 8-17-60 , and that death occurred at 5 AM , from the causes and on the date stated above.							
22a. SIGNATURE E.W. Ditto Jr.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) E.W. DITTO JR.				22d. ADDRESS HAGERSTOWN MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8/20/60		23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEMETERY		23d. LOCATION (City, town, or county) (State) HAGERSTOWN MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE R. Franklin Poyner				25a. REC'D BY REGISTRAR HAGERSTOWN MARYLAND		25b. REGISTRAR'S SIGNATURE Charles E. Knapp	
				DATE AUG 23 '60			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

9706

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09666

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport	
c. LENGTH OF STAY IN 1b 44 yrs.		d. STREET ADDRESS 27 Conococheague Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 27 Conococheague Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle Edmond Last Mc Cauley		4. DATE OF DEATH Month Aug. Day 27 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 8 1884
9. AGE (In years lost birthday) 76 yrs.		10. IF UNDER 1 YEAR Months 4 Days 18	11. IF UNDER 24 HRS. Hours 18 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Tannery	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Samuel Mc Cauley	
14. MOTHER'S MAIDEN NAME Laura Stouffer		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 215 09 7412		17. INFORMANT Mrs. Sarah Jane Mc Cauley Williamsport	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral arteriosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) 1 Yr 5 Yrs.		INTERVAL BETWEEN ONSET AND DEATH 1 Yr 5 Yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1958 19 to 8/27/60 19, that (I) (we) last saw the deceased alive on 8/25/60 19 and that death occurred at 6A M, from the causes and on the date stated above.			
22a. SIGNATURE Walter H. Shealy		22b. DATE SIGNED 8/28/60	
22c. PHYSICIAN'S NAME (Type) Walter H. Shealy M. D.		22d. ADDRESS Sharpsburg, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 29-60	
23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery		23d. LOCATION (City, town, or county) (State) Williamsport Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Albert Leaf Williamsport Maryland		25a. REC'D BY REGISTRAR DATE AUG 30 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Frank			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

302

09667

9707

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Williamsport Sanitarium		d. STREET ADDRESS 30 Randolph Ave	
3. NAME OF DECEASED (Type or print) First Middle Last BERTHA (NMN) McCoy		4. DATE OF DEATH Month Day Year August 3 1960 19	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 1 1871
9. AGE (In years lost birthday) 89 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Funkstown Wash Co Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Archibald McCoy		14. MOTHER'S MAIDEN NAME Martha Furry	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. unable to locate Mrs Mary Ellen Webb	
17. INFORMANT 18 E. Lincoln Ave Hagerstown Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerosis 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) General Arterio Sclerosis (c) Ischemic		ONSET AND DEATH recent 15/4 15/4	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8-1-60 to 8-3-60 , that (I) (we) last saw the deceased alive on 8-1-60 , and that death occurred on 8-3-60 M, from the causes and on the date stated above.			
22a. SIGNATURE A. E. W. Dittus		22b. DATE SIGNED 8/3/60	
22c. PHYSICIAN'S NAME (Type) Dr E W Dittus		22d. ADDRESS Hagerstown Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/5/60	
23c. NAME OF CEMETERY OR CREMATORY Funkstown Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Wash Co Md	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		25a. REC'D BY REGISTRAR AUG 5 '60	
ADDRESS Hagerstown Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



2050

0000

000

CENTINATE OF CATH

Washington

Washington

Washington

Washington

10 77

30 Washington Ave

30 Washington Ave

BERTHA (MRS) MOORE

Female White born January 1 1871

Have lived in Washington D.C. USA

Married May 1900

Remains to be seen for many years

[Faint, mostly illegible handwritten text and signatures follow, including what appears to be a signature at the bottom right.]

1
M
X
I

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
M
X
I

9721

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09668

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hancock</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Hazel</u> Middle <u>Rebecca</u> Last <u>McCusker</u>				4. DATE OF DEATH Month <u>8</u> Day <u>12</u> Year <u>1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 2. 1903</u>		9. AGE (In years last birthday) <u>57</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Hancock Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Charles Munson</u>			
14. MOTHER'S MAIDEN NAME <u>Mollie Bishop</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>Robert McCusker Rural 1 Hancock Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>arterio sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio vasc. disease</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> Month <u> </u> Day <u> </u> Year <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>July 1, 1960</u> to <u>Aug 12, 1960</u> that (I) (we) last saw the deceased alive on <u>Aug 12, 1960</u> and that death occurred at <u>8:30 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>M. Shaffer</u>				22b. DATE SIGNED <u> </u>		22c. PHYSICIAN'S NAME (Type) <u>L M SHAFFER MD</u>	
22d. ADDRESS <u>Hancock, Md</u>				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>8.15.60</u>		23c. NAME OF CEMETERY OR CREMATOR <u>Mt Olivet Presbyterian</u>	
23d. LOCATION (City, town, or county) <u>Rural Hancock Washington</u>				23e. (State) <u>Md.</u>		23f. FUNERAL DIRECTOR'S SIGNATURE <u>Howard J. Skow</u>	
23g. ADDRESS <u>Hancock Md</u>				23h. REC'D BY REGISTRAR <u> </u>		23i. REGISTRAR'S SIGNATURE <u>Carlton S. Hume</u>	
23j. DATE <u>AUG 17 '60</u>				23k. REGISTRAR'S SIGNATURE <u> </u>			

1908

CERTIFICATE OF DEATH

1921



Local Board of Health
City of New York
No. 1000
Date of Death
Place of Death
Cause of Death
Age at Death
Sex
Race
Marital Status
Occupation
Residence
Signature of Registrar



Signature of Physician
Signature of Coroner
Signature of Registrar
Date of Death
Place of Death
Cause of Death
Age at Death
Sex
Race
Marital Status
Occupation
Residence
Signature of Registrar

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09669

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kemps Mill nr. Hagers.</u> c. LENGTH OF STAY IN 1b <u>Indefinite</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) _____				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>512 Salem Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Earl</u> Middle <u>E.</u> Last <u>Messner</u>			4. DATE OF DEATH Month <u>August</u> Day <u>13</u> Year <u>1960</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>Jan. 15, 1927</u>		9. AGE (In years last birthday) <u>33</u> yrs.		10. IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Charles E. Messner</u>			14. MOTHER'S MAIDEN NAME <u>Lula B. Stitley</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>219-20-3009</u>		17. INFORMANT <u>Charles E. Messner</u> Address <u>512 Salem Ave. Hagerstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SHOCK FOLLOWING HEMORRHAGE FROM SELF INFLICTED KNIFE WOUNDS</u> DUE TO (b) _____ DUE TO (c) _____ CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTENSIONAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>SUICIDE BY SLASHING BOTH WRISTS & NECK</u>							
20c. TIME OF INJURY Month, Day, Year <u>8/12/60</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>KEMP MILL RD. HAGERSTOWN, WASH. MD</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>DR. F. W. DITTO, JR.</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
EXAMINER'S NAME (Type) <u>DR. F. W. DITTO, JR.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-16-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Blue Ridge Cemetery</u>			
22d. LOCATION (City, town, or county) <u>Thurmont, Maryland</u>		24a. REC'D BY REGISTRAR <u>AUG 17 '60</u>					
24b. REGISTRAR'S SIGNATURE <u>Raymond E. Creager</u>		24c. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased JAMES H. HARRIS		Age 45		Sex Male		Race White	
Date of Death August 14, 1900		Place of Death Home		Cause of Death Suicide by slashing both wrists & neck		Manner of Death Suicide	
Residence 1234 Main St., Baltimore, Md.		Occupation Clerk		Medical History None		Social History None	
Physician Dr. E. W. Little, Jr.		Hospital None		Mental History None		Toxicology None	
Signature of Medical Examiner Dr. E. W. Little, Jr.		Signature of Coroner None		Signature of Police Officer None		Signature of Witness None	

SHOCK FOLLOWING HEMORRHAGE
FROM SELF INFLICTED KNIFE WOUNDS

SUICIDE BY SLASHING BOTH WRISTS & NECK

AUG. 14, 1900

DR. E. W. LITTLE, JR.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9681

CERTIFICATE OF DEATH

Reg. Dist. No.

09670

1. PLACE OF DEATH o. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY FREDERICK	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN lb 1 WEEK	
d. NAME OF HOSPITAL (If not in hospital, give street address) 900 PRESTON RD.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LAURA Middle BELLE Last MICHAEL		4. DATE OF DEATH Month AUGUST Day 21 Year 19 60	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/18/1874
9. AGE (In years lost birthday) yrs. 86		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME WILLIAM H. SHORB	
14. MOTHER'S MAIDEN NAME MARY MIKESELL		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT MRS. R. DEAN STICKELL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Arterio-sclerotic Heart Disease (c) 10 yrs		INTERVAL BETWEEN ONSET AND DEATH 3 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-21-60 , 19 60 , to 8-21-60 , 19 60 , that I last saw the deceased alive on 8-21-60 , 19 60 , and that death occurred at 9:30 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE A. E. Smith M.D. August 21, 1960 PHYSICIAN'S NAME (Type) Dr. E. W. Smith			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/23/60	
22c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEM.		22d. LOCATION (City, town, or county) (State) FREDERICK MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Normant, Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE AUG 23 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

CERTIFICATE OF DEATH

3681

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

1 M 081 1 2 1 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. 1 2 1 VS A15 (4) 15M 10/57

9682 CERTIFICATE OF DEATH

Reg. Dist. No.

09671

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>5 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rural Smithsburg</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS <u>1 R.D.2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edith</u> Middle <u>E.</u> Last <u>MILLER</u>				4. DATE OF DEATH Month <u>August</u> Day <u>7</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 21, 1875</u>		9. AGE (In years last birthday) yrs. <u>85</u>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Edgemont, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Abram Weddle</u>				14. MOTHER'S MAIDEN NAME <u>Alice E. Stouffer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Mrs. Clarence Frey Smithsburg, Md. R.D.2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolus</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pancreatitis</u> DUE TO (c) <u>Choliliathisis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>5 days</u> <u>1 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>7-24</u> , 19 <u>59</u> , to <u>8-7</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>8-7</u> , 19 <u>60</u> , and that death occurred at <u>2:40 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles F. Hess</u>		M.D. <u>Smithsburg, Maryland</u>		DATE SIGNED <u>8-8-60</u>		ADDRESS (Street, city or town, state)	
PHYSICIAN'S NAME (Type) <u>Charles F. Hess, M.D.</u>		<u>Smithsburg, Maryland</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/10/1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Welty's</u>		22d. LOCATION (City, town, or county) (State) <u>Smithsburg, Md. R.D.2</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter J. Glore</u>		ADDRESS <u>Waynesboro, Pa.</u>		24a. REC'D BY REGISTRAR <u>DATE AUG 11 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles F. Hess</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. OCCUPATION		6. MARITAL STATUS	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF DECEASED	
16. SIGNATURE OF FUNERAL HOME		17. SIGNATURE OF BURIAL PLACE		18. SIGNATURE OF INTERVIEWER	
19. SIGNATURE OF CORONER		20. SIGNATURE OF JURY		21. SIGNATURE OF JUDGE	
22. SIGNATURE OF SHERIFF		23. SIGNATURE OF CLERK		24. SIGNATURE OF RECORDER	
25. SIGNATURE OF ARCHIVIST		26. SIGNATURE OF INDEXER		27. SIGNATURE OF FILE CLERK	
28. SIGNATURE OF ASSISTANT CLERK		29. SIGNATURE OF CHIEF CLERK		30. SIGNATURE OF DEPUTY CHIEF CLERK	
31. SIGNATURE OF ASSISTANT DEPUTY CHIEF CLERK		32. SIGNATURE OF CLERK IN CHARGE		33. SIGNATURE OF CLERK IN CHARGE	
34. SIGNATURE OF CLERK IN CHARGE		35. SIGNATURE OF CLERK IN CHARGE		36. SIGNATURE OF CLERK IN CHARGE	
37. SIGNATURE OF CLERK IN CHARGE		38. SIGNATURE OF CLERK IN CHARGE		39. SIGNATURE OF CLERK IN CHARGE	
40. SIGNATURE OF CLERK IN CHARGE		41. SIGNATURE OF CLERK IN CHARGE		42. SIGNATURE OF CLERK IN CHARGE	
43. SIGNATURE OF CLERK IN CHARGE		44. SIGNATURE OF CLERK IN CHARGE		45. SIGNATURE OF CLERK IN CHARGE	
46. SIGNATURE OF CLERK IN CHARGE		47. SIGNATURE OF CLERK IN CHARGE		48. SIGNATURE OF CLERK IN CHARGE	
49. SIGNATURE OF CLERK IN CHARGE		50. SIGNATURE OF CLERK IN CHARGE		51. SIGNATURE OF CLERK IN CHARGE	
52. SIGNATURE OF CLERK IN CHARGE		53. SIGNATURE OF CLERK IN CHARGE		54. SIGNATURE OF CLERK IN CHARGE	
55. SIGNATURE OF CLERK IN CHARGE		56. SIGNATURE OF CLERK IN CHARGE		57. SIGNATURE OF CLERK IN CHARGE	
58. SIGNATURE OF CLERK IN CHARGE		59. SIGNATURE OF CLERK IN CHARGE		60. SIGNATURE OF CLERK IN CHARGE	
61. SIGNATURE OF CLERK IN CHARGE		62. SIGNATURE OF CLERK IN CHARGE		63. SIGNATURE OF CLERK IN CHARGE	
64. SIGNATURE OF CLERK IN CHARGE		65. SIGNATURE OF CLERK IN CHARGE		66. SIGNATURE OF CLERK IN CHARGE	
67. SIGNATURE OF CLERK IN CHARGE		68. SIGNATURE OF CLERK IN CHARGE		69. SIGNATURE OF CLERK IN CHARGE	
70. SIGNATURE OF CLERK IN CHARGE		71. SIGNATURE OF CLERK IN CHARGE		72. SIGNATURE OF CLERK IN CHARGE	
73. SIGNATURE OF CLERK IN CHARGE		74. SIGNATURE OF CLERK IN CHARGE		75. SIGNATURE OF CLERK IN CHARGE	
76. SIGNATURE OF CLERK IN CHARGE		77. SIGNATURE OF CLERK IN CHARGE		78. SIGNATURE OF CLERK IN CHARGE	
79. SIGNATURE OF CLERK IN CHARGE		80. SIGNATURE OF CLERK IN CHARGE		81. SIGNATURE OF CLERK IN CHARGE	
82. SIGNATURE OF CLERK IN CHARGE		83. SIGNATURE OF CLERK IN CHARGE		84. SIGNATURE OF CLERK IN CHARGE	
85. SIGNATURE OF CLERK IN CHARGE		86. SIGNATURE OF CLERK IN CHARGE		87. SIGNATURE OF CLERK IN CHARGE	
88. SIGNATURE OF CLERK IN CHARGE		89. SIGNATURE OF CLERK IN CHARGE		90. SIGNATURE OF CLERK IN CHARGE	
91. SIGNATURE OF CLERK IN CHARGE		92. SIGNATURE OF CLERK IN CHARGE		93. SIGNATURE OF CLERK IN CHARGE	
94. SIGNATURE OF CLERK IN CHARGE		95. SIGNATURE OF CLERK IN CHARGE		96. SIGNATURE OF CLERK IN CHARGE	
97. SIGNATURE OF CLERK IN CHARGE		98. SIGNATURE OF CLERK IN CHARGE		99. SIGNATURE OF CLERK IN CHARGE	
100. SIGNATURE OF CLERK IN CHARGE		101. SIGNATURE OF CLERK IN CHARGE		102. SIGNATURE OF CLERK IN CHARGE	

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

26

27

28

29

30

31

32

33

34

35

36

37

38

39

40

41

42

43

44

45

46

47

48

49

50

51

52

53

54

55

56

57

58

59

60

61

62

63

64

65

66

67

68

69

70

71

72

73

74

75

76

77

78

79

80

81

82

83

84

85

86

87

88

89

90

91

92

93

94

95

96

97

98

99

100

M

1

9683

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

302

09672

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash County Hospital				d. STREET ADDRESS 631 West Franklin St			
3. NAME OF DECEASED (Type or print) First Middle Last THOMAS ELWOOD MILLER Sr				4. DATE OF DEATH Month Day Year August 30 1960 19			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 17 1913		9. AGE (In years lost birthday) yrs. 47	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet Metal Worker		10b. KIND OF BUSINESS OR INDUSTRY ----		11. BIRTHPLACE (State or foreign country) W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James L. Miller				14. MOTHER'S MAIDEN NAME Annie V. Gantt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) ----- 212-14-6601		17. INFORMANT Address Mrs Ramona Miller 631 W. Franklin St			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH linked to							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/30/60 to 8/30/60 , that (I) (we) last saw the deceased alive on 8/30/60 , and that death occurred at 11:00 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Ralph F. Young				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8/31/60	
22c. PHYSICIAN'S NAME (Type) Ralph F. Young				22d. ADDRESS Williamsport Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/2/60		23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		23d. LOCATION (City, town, or county) (State) Sleepy Creek Morgan Co W. Va	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.				25a. REC'D BY REGISTRAR DATE SEP 2 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

00672

508

CENTRAL OFFICE

5083

1

Washington

DOA

101 West Franklin St

MILLEN ST

THOMAS ALVON

June 17 1913

1100 West Franklin St

1100 West Franklin St

Annals of the

Annals of the

1100 West Franklin St

1100 West Franklin St

1100 West Franklin St

CHIEF

MADE

1100 West Franklin St

1100 West Franklin St

1100 West Franklin St

1100 West Franklin St

1100 West Franklin St

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
9684
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09673

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 10 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1924 Virginia Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Harry Middle Tilghmanton Last Moats		4. DATE OF DEATH Month Aug. Day 14 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 10 1877
9. AGE (In years last birthday) 83		10. IF UNDER 1 YEAR Months 6 Days 3	
11. IF UNDER 24 HRS. Hours Min. 		12. CITIZEN OF WHAT COUNTRY? U. S. A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Organ Co.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME Harry Moats		14. MOTHER'S MAIDEN NAME Susan Davis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219 12 0507	
17. INFORMANT Gardner Moats		18. ADDRESS 1924 Virginia Ave. Hagerstown Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CC. Myocardial Infarction 4 20.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH 1 Day			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/13/60 to 8/14/60 that (I) (we) last saw the deceased alive on 8/13/60 and that death occurred at 11 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Ralph F. Young		22b. DATE SIGNED 8/16/60	
22c. PHYSICIAN'S NAME (Type) RALPH F. YOUNG		22d. ADDRESS Williamsport, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 17-60	
23c. NAME OF CEMETERY OR CREMATORY Manor Cemetery		23d. LOCATION (City, town, or county) (State) Near Tilghmanton Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Albert L. Leaf Williamsport, Md.		25a. REC'D BY REGISTRAR AUG 18 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

834 V. C.

★ 9/24

ON LINE

520

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

1

9723

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09674

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharpsburg		c. LENGTH OF STAY IN 1b 70 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 107 S. Mechanic Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lillie Middle May Last Mongan		4. DATE OF DEATH Month Aug. Day 6 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 28 1872
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months 7 Days 8 Hours Min. 	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Keedysville Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Jonas Jones		14. MOTHER'S MAIDEN NAME Mary Elizabeth Lopp	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Paul Stockslager		18. ADDRESS 107 S. Mechanic St. Sharpsburg Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) 		INTERVAL BETWEEN ONSET AND DEATH One Day 5 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 5 19 60 to Aug 6 19 60 that (I) (we) lost saw the deceased alive on Aug 6 19 60 and that death occurred on Aug 6 19 60 from the causes and on the date stated above.			
22a. SIGNATURE Lillian H. H. H. H.		22b. DATE SIGNED 8-7-60	
22c. PHYSICIAN'S NAME (Type) Howard H. H. H.		22d. ADDRESS Shepherdstown W.Va	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 8 1960	
23c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		23d. LOCATION (City, town, or county) (State) Sharpsburg Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Edith V. Leal Williams		25a. REC'D BY REGISTRAR DATE AUG 9 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. H. H.			

45074

CERTIFICATE OF BIRTH

9753



Washington

Marion

Washington

Sharonburg

10753

Sharonburg

10753, Sharonburg

10753, Sharonburg

10753, Sharonburg

10753, Sharonburg

10753, Sharonburg

10753, Sharonburg

10753, Sharonburg

10753, Sharonburg

10753, Sharonburg

10753, Sharonburg

10753, Sharonburg

10753, Sharonburg

10753, Sharonburg

10753, Sharonburg

10753, Sharonburg

10753, Sharonburg

10753, Sharonburg

10753, Sharonburg

10753, Sharonburg

10753, Sharonburg



10753, Sharonburg

10753, Sharonburg

10753, Sharonburg

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

1
9708
M
090
I
0
1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09675

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>West Virginia</u> b. COUNTY <u>Charleston</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>				c. LENGTH OF STAY IN 1b <u>2 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Charleston</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u>				d. STREET ADDRESS <u>300 S. Church St.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Virginia</u> Middle <u>H.</u> Last <u>Osbourn</u>				4. DATE OF DEATH Month <u>August</u> Day <u>5</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 4, 1880</u>		9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months <u>5</u> Days <u>19</u> Hours <u>19</u> Min. <u>19</u>	IF UNDER 24 HRS. Months <u>5</u> Days <u>19</u> Hours <u>19</u> Min. <u>19</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Charleston</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Laurence Osbourn</u>				14. MOTHER'S MAIDEN NAME <u>Clara C. Ashbaugh</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>			
17. INFORMANT <u>Mrs. Paxson Whitmore</u>				Address <u>300 S. Church St. Charleston W. Va.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332+ DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Venous Thrombosis</u> DUE TO (c) <u>none</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>2 mos</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (1) this hospital attended the deceased from <u>Aug 1</u> 19 <u>60</u> to <u>Aug 8</u> 19 <u>60</u> , that (u) (we) last saw the deceased alive on <u>Aug 2</u> 19 <u>60</u> and that death occurred at <u>2:30</u> M., from the causes and on the date stated above.							
22a. SIGNATURE <u>M.E. Byrkit</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8-5-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>M.E. Byrkit</u>				22d. ADDRESS <u>28 W Potomac Wmpt Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Aug 9, 1960</u>		23b. DATE THEREOF <u>Aug 9, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>EDGE HILL</u>		23d. LOCATION (City, town, or county) (State) <u>CHARLES TOWN W. VA.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Scott Munnich & Son Hagerstown Md</u>				ADDRESS <u>Hagerstown Md</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 12 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>			

48037

CERTIFICATE OF DEATH

9308

(M)

(1)

John Doe, of the County of ... State of ...
born ... died ...
Cause of death ...

General and Venues ...
The undersigned ...
Witness my hand and seal ...

Witness my hand and seal ...
Date ...
Signature ...
Official Seal ...

9685

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 2 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Washington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington County Hospital Smithsburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital						d. STREET ADDRESS Hagerstown, Md.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First John		Middle Samuel		Last Portner		4. DATE OF DEATH Month Aug.		Day 6		Year 19 60	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 4, 1960		9. AGE (In years lost birthday) yrs. 2		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None				11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Harry E. Portner						14. MOTHER'S MAIDEN NAME Peggy Stottlemeyer					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none		INFORMANT Harry E. Portner, R. D. 1 Smithsburg, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 DUE TO Atelectasis Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) Prematurity DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Smithsburg		(County) (State)	
21. I certify that I attended the deceased from 8/4/1960 to 8/6/1960 , that I last saw the deceased alive on 8/6/60 , 19 60 , and that death occurred at 5:50 P.M. from the causes and on the date stated above.											
ACTUAL SIGNATURE A. M. Bacon Jr				M.D. 101 King St Hagerstown Md				ADDRESS (Street, city or town, state) 2/7/60			
PHYSICIAN'S NAME (Type) A. M. BACON JR											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Aug. 7, 1960		22c. NAME OF CEMETERY OR CREMATORY Pleasant Valley Cemetary		22d. LOCATION (City, town, or county) Smithsburg, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son Smithsburg, Md.						DATE AUG 9 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kneale			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09677

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY WASH.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b LIFE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON CO. HOSPITAL			d. STREET ADDRESS 1117 N. LOCUST ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) ALBERT D. POWELL SR.			4. DATE OF DEATH Month 8 Day 8 Year 19 60		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN 26, 1899		9. AGE (In years last birthday) yrs. 61
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FIREMAN		10b. KIND OF BUSINESS OR INDUSTRY W.M.R.R.		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME WILLIAM POWELL			14. MOTHER'S MAIDEN NAME MOLLIE GROVE		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 705-10-7095		17. INFORMANT ALBERT D. POWELL JR. Address 221 SUMMER ST. HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerosis DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 1 hour
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 1958 to July 1960 , that (I) (we) last saw the deceased alive on July 5, 1960 , and that death occurred at 2 PM , from the causes and on the date stated above.					
22a. SIGNATURE Robert V. h. Campbell M.D.			22b. DATE SIGNED 8/8/60		
22c. PHYSICIAN'S NAME (Type) Robert V. h. Campbell			22d. ADDRESS HAGERSTOWN MD		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8/10/1960		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL	
				23d. LOCATION (City, town, or county) (State) HAGERSTOWN, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE FRED W. KRAISS ADDRESS HAGERSTOWN, MD.			25a. REC'D BY REGISTRAR DATE AUG 10 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

9687

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09678

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 03 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. STREET ADDRESS 1847 Rolling Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First THELMA Middle LORENA Last PURDHAM		4. DATE OF DEATH Month August Day 7 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 21, 1902
9. AGE (In years lost birthday) 57 yrs.		10. IF UNDER 1 YEAR Months 57 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Luray, Virginia	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter R. Miller		14. MOTHER'S MAIDEN NAME Louise Young	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Josephine Coss		Address Hagerstown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334X DUE TO Cerebral apoplexy Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis cerebral (c) Diabetes mellitus; Obesity severe; fracture of hip		INTERVAL BETWEEN ONSET AND DEATH 9 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus; Obesity severe; fracture of hip		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Fell in home -> hip fracture		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 5:30 a. m. 7-3 p. m. 1960		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Hagerstown Wash Md.	
21. I certify that (I) (this hospital) attended the deceased from 7-30-1960 to Death 19 60 , that (I) (we) last saw the deceased alive on 8-6-1960 and that death occurred at 7:45 PM from the causes and on the date stated above.			
22a. SIGNATURE Robert F. Keadle		22b. DATE SIGNED 8-8-60	
22c. PHYSICIAN'S NAME (Type) Robert F. Keadle, M. D.		22d. ADDRESS 318 N. Potomac St., Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/10/1960	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Suter - Rouzer Funeral Home		ADDRESS Hagerstown, Md.	
25a. REC'D BY REGISTRAR AUG 11 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Kears	

[illegible]

Discussion

—

C95.72-10000

Abstract: 75-250

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

9688

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09679

1. PLACE OF DEATH o. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 35 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				d. STREET ADDRESS 44 1/2 East Franklin Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First MARGIE Middle ALICE Last RAFFENSBERGER				4. DATE OF DEATH Month August Day 17 Year 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 6, 1886	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William Stotelmeyer				14. MOTHER'S MAIDEN NAME Mary J. Bowie			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Robert Cashman Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 331 X IMMEDIATE CAUSE (a) Cardiovascular Collapse DUE TO (b) Cerebral hemorrhage DUE TO (c) Arteriosclerosis of the Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from Aug 5, 1960 to Aug 16, 1960 that (I) (we) last saw the deceased alive on Aug 16, 1960 , and that death occurred at 3:15 P.M. from the causes and on the date stated above. 22a. SIGNATURE L. S. Smith 22c. PHYSICIAN'S NAME (Type) Louis G. Guffey MD 22d. ADDRESS 119 E. Antietam St. 22b. DATE SIGNED Aug 16, 1960				INTERVAL BETWEEN ONSET AND DEATH min 50 sec hrs			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 8/20/1960		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	
23d. LOCATION (City, town, or county) (State) Hagerstown, Maryland							
24. FUNERAL DIRECTOR'S SIGNATURE Super Rouzer Funeral Home R. Franklin Rouzer				ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE AUG 23 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Howard							

not paid.

1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 26

7285 5

de la vie de l'homme

552-73

44

Figure 2

circulation.

04077

C

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

1
M
081
9689
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
09680

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b FEW DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL		d. STREET ADDRESS NONE	
3. NAME OF DECEASED (Type or print) JOHN First MARTIN Middle SHOEMAKER Last		4. DATE OF DEATH Month AUGUST Day 25 Year 19 60	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 19, 1871
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months 8 Days 8 Hours 8 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING	
11. BIRTHPLACE (State or foreign country) MILLSTONE, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE SHOEMAKER		14. MOTHER'S MAIDEN NAME SUZANNE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT OSCAR B. SHOEMAKER Address HAGERSTOWN RD. 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 177X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma Prostate DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 2 hrs. 7/4/56
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/4/56 to 8/25/60 , that (I) (we) last saw the deceased alive on 8/25/60 , and that death occurred at 7:55 P.M. from the causes and on the date stated above.			
22a. SIGNATURE J. G. Warden M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) J. G. Warden, M. D.		22d. ADDRESS 832 Potomac Ave., Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF AUG. 28, 1960	
23c. NAME OF CEMETERY OR CREMATORY STONE BRIDGE CEM.		23d. LOCATION (City, town, or county) (State) MILLSTONE, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE John F. Clark ADDRESS CLEAR SPRING, MD.		25a. REC'D BY REGISTRAR DATE AUG 29 '60	
		25b. REGISTRAR'S SIGNATURE Arthur S. Kneass	

00880

STATE OF OHIO
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

00880



NAME OF DECEASED

AGE

SEX

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09681

Reg. Dist. No. 302

9724

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonsboro R # 1		c. LENGTH OF STAY IN Yr 24 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonsboro R # 1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bakersville - Fairplay Rd				d. STREET ADDRESS Bakersville - fairplay Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOSEPHINE Middle ELIZABETH Last SKELTON				4. DATE OF DEATH Month August Day 19 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 16 1905	9. AGE (In years last birthday) 55 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Bakersville Wash Co Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Sisler				14. MOTHER'S MAIDEN NAME Maggie Gaylor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs Mary J. Thomas Boonsboro R # 1			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot Wound Involving Entire Face & Head DUE TO (b) (Self Inflicted) Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) 				INTERVAL BETWEEN ONSET AND DEATH Instant			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Patient shot herself with shotgun.					
20c. TIME OF INJURY Hour 9:15 o. m. am. Month, Day, Year 8-19- 19 60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Boonsboro R # 1, Washington, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>[Signature]</i> EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED 8-20-60							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/21/60		22c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery		22d. LOCATION (City, town, or county) (State) Bakersville Wash Co Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.				24a. REC'D BY REGISTRAR DATE AUG 23 '60		24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it as a "pending" certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35 Yrs	
4. DATE OF DEATH April 4, 1968		5. TIME OF DEATH 2:01 PM		6. PLACE OF DEATH Room 306, Federal Bureau of Investigation, Washington, D.C.	
7. OCCUPATION Attorney		8. MARITAL STATUS Single		9. COLOR Caucasian	
10. BIRTH DATE March 22, 1933		11. BIRTH PLACE Jackson, Tennessee		12. EDUCATION High School Graduate	
13. PREVIOUS MARRIAGES None		14. PREVIOUS DEATHS None		15. PREVIOUS SURGICAL OPERATIONS None	
16. PREVIOUS ILLNESSES None		17. PREVIOUS TRAUMAS None		18. PREVIOUS DRUG USE None	
19. PREVIOUS ALCOHOL USE None		20. PREVIOUS TOBACCO USE None		21. PREVIOUS OTHER HABITS None	
22. PREVIOUS MENTAL ILLNESS None		23. PREVIOUS PHYSICAL ILLNESS None		24. PREVIOUS SOCIAL HISTORY None	
25. PREVIOUS LEGAL HISTORY None		26. PREVIOUS MILITARY HISTORY None		27. PREVIOUS FOREIGN TRAVEL None	
28. PREVIOUS RESIDENCE None		29. PREVIOUS EMPLOYMENT None		30. PREVIOUS EDUCATION None	
31. PREVIOUS MARRIAGES None		32. PREVIOUS DEATHS None		33. PREVIOUS SURGICAL OPERATIONS None	
34. PREVIOUS ILLNESSES None		35. PREVIOUS TRAUMAS None		36. PREVIOUS DRUG USE None	
37. PREVIOUS ALCOHOL USE None		38. PREVIOUS TOBACCO USE None		39. PREVIOUS OTHER HABITS None	
40. PREVIOUS MENTAL ILLNESS None		41. PREVIOUS PHYSICAL ILLNESS None		42. PREVIOUS SOCIAL HISTORY None	
43. PREVIOUS LEGAL HISTORY None		44. PREVIOUS MILITARY HISTORY None		45. PREVIOUS FOREIGN TRAVEL None	
46. PREVIOUS RESIDENCE None		47. PREVIOUS EMPLOYMENT None		48. PREVIOUS EDUCATION None	
49. PREVIOUS MARRIAGES None		50. PREVIOUS DEATHS None		51. PREVIOUS SURGICAL OPERATIONS None	
52. PREVIOUS ILLNESSES None		53. PREVIOUS TRAUMAS None		54. PREVIOUS DRUG USE None	
55. PREVIOUS ALCOHOL USE None		56. PREVIOUS TOBACCO USE None		57. PREVIOUS OTHER HABITS None	
58. PREVIOUS MENTAL ILLNESS None		59. PREVIOUS PHYSICAL ILLNESS None		60. PREVIOUS SOCIAL HISTORY None	
61. PREVIOUS LEGAL HISTORY None		62. PREVIOUS MILITARY HISTORY None		63. PREVIOUS FOREIGN TRAVEL None	
64. PREVIOUS RESIDENCE None		65. PREVIOUS EMPLOYMENT None		66. PREVIOUS EDUCATION None	
67. PREVIOUS MARRIAGES None		68. PREVIOUS DEATHS None		69. PREVIOUS SURGICAL OPERATIONS None	
70. PREVIOUS ILLNESSES None		71. PREVIOUS TRAUMAS None		72. PREVIOUS DRUG USE None	
73. PREVIOUS ALCOHOL USE None		74. PREVIOUS TOBACCO USE None		75. PREVIOUS OTHER HABITS None	
76. PREVIOUS MENTAL ILLNESS None		77. PREVIOUS PHYSICAL ILLNESS None		78. PREVIOUS SOCIAL HISTORY None	
79. PREVIOUS LEGAL HISTORY None		80. PREVIOUS MILITARY HISTORY None		81. PREVIOUS FOREIGN TRAVEL None	
82. PREVIOUS RESIDENCE None		83. PREVIOUS EMPLOYMENT None		84. PREVIOUS EDUCATION None	
85. PREVIOUS MARRIAGES None		86. PREVIOUS DEATHS None		87. PREVIOUS SURGICAL OPERATIONS None	
88. PREVIOUS ILLNESSES None		89. PREVIOUS TRAUMAS None		90. PREVIOUS DRUG USE None	
91. PREVIOUS ALCOHOL USE None		92. PREVIOUS TOBACCO USE None		93. PREVIOUS OTHER HABITS None	
94. PREVIOUS MENTAL ILLNESS None		95. PREVIOUS PHYSICAL ILLNESS None		96. PREVIOUS SOCIAL HISTORY None	
97. PREVIOUS LEGAL HISTORY None		98. PREVIOUS MILITARY HISTORY None		99. PREVIOUS FOREIGN TRAVEL None	
100. PREVIOUS RESIDENCE None		101. PREVIOUS EMPLOYMENT None		102. PREVIOUS EDUCATION None	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

9690

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09682

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 31 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 220 Frederick Street				d. STREET ADDRESS 1220 Frederick Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First LILLIAN Middle ALBERTA Last SLICK				4. DATE OF DEATH Month August Day 5 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 11, 1895	
9. AGE (In years lost birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Wolfsville, Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Harry G. Maugans, Sr.				14. MOTHER'S MAIDEN NAME Salie Ramsburg			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none		17. INFORMANT Mr. William H. Slick Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 pulmonary edema DUE TO (b) arteriosclerotic C.V.D. DUE TO (c) ser. years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				INTERVAL BETWEEN ONSET AND DEATH ser. years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 7/28/59 19____, to 8/5/60 19____, that (I) (we) last saw the deceased alive on 8/4/60 19____, and that death occurred at 2A M. from the causes and on the date stated above.							
22a. SIGNATURE Howard N. Weeks				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8/5/60	
22c. PHYSICIAN'S NAME (Type) Howard N. Weeks, M.D.				22d. ADDRESS 136 North Potomac Street Hagerstown, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/7/1960		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Suter - Rouzer Funeral Home				ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE AUG 11 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. Kline							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9691

09683
Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) b. STATE <u>Pennsylvania</u> c. COUNTY <u>West Moreland</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Latrobe</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>				d. STREET ADDRESS <u>Route #3</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARLIN SCOTT SMITH</u>				4. DATE OF DEATH Month Day Year <u>August 21, 1960 19</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 24, 1958</u>	
9. AGE (In years last birthday) <u>2</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----				10b. KIND OF BUSINESS OR INDUSTRY -----			
11. BIRTHPLACE (State or foreign country) <u>Hagerstown Wash Co Md</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Eugene Elmer Smith</u>				14. MOTHER'S MAIDEN NAME <u>Evelyn Regina Hull</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -----				16. SOCIAL SECURITY NO. -----			
17. INFORMANT <u>Eugene Smith, Route #3, Latrobe, Pa.</u>				Address -----			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> DUE TO <u>Fracture Pelvis</u> Conditions, if any, which gave rise to immediate cause (b) <u>Fracture Left Femur</u> (c) <u>Cerebral Concussion</u> DUE TO <u>Probable Internal Injury</u> DUE TO <u>Probable Internal Injury</u> INTERVAL BETWEEN ONSET AND DEATH <u>11 Hours</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Patient struck by auto when he ran out on public road.</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>5:45</u> p. m. <u>8-20-1960</u>				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Walnut Point Road, Hagerstown, Washington, Maryland</u>				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>[Signature]</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 8-22-60			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>8/23/60</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Shanktown Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Shanktown, Wash Co Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman, Hagerstown, Md</u>				24a. REC'D BY REGISTRAR <u>AUG 24 '60</u>			
24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				24c. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

970

09738

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HALEWAY</u>				c. LENGTH OF STAY IN 1b <u>ONE WEEK</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MARTIN MANGOR NURSING HOME</u>				e. STREET ADDRESS <u>17 GLENSIDE AVENUE</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>EFFIE MAY SPRECHER</u>				4. DATE OF DEATH Month Day Year <u>AUGUST - 12 - 1960</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL 24 - 1878</u>		9. AGE (In years lost birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min. <u>3 18</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>WALNUT POINT WASH. D.C. M.D. U.S.A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>ANDREW J. HARSH</u>				14. MOTHER'S MAIDEN NAME <u>ANNA V. BUCHANAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>EDGAR C. SPRECHER</u> Address <u>17 GLENSIDE AVE HAGERSTOWN MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acc. by cardiac defraction</u> <u>420.1</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (c) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 _____		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8/4/60</u> to <u>8/12/60</u> , that (I) (we) last saw the deceased alive on <u>8/12/60</u> 19_____, and that death occurred at <u>4:30</u> P. M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Joseph Young</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8/12/60</u>	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>AUG. 15, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST. PAULS CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>HAGERSTOWN MD. R. 40 WEST</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. West</u>				ADDRESS <u>BOONSBORO MARYLAND</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 18 '60</u>	
						25b. REGISTRAR'S SIGNATURE <u>Arthur L. Finner</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10738

MINISTRE DU TRAVAIL
DEPARTMENT OF LABOUR
CERTIFICATE OF DEATH

2106



[Faint, illegible handwriting and stamps are visible in this section, likely representing a signature and official seals.]

9692

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09684

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 2 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
3. NAME OF DECEASED (Type or print) First Middle Last REV. AUGUST KARL STENZEL		4. DATE OF DEATH Month Day Year August 24 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 27, 1912
9. AGE (In years last birthday) 48 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lutheran Minister		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME August A. Stenzel		14. MOTHER'S MAIDEN NAME Matilda Johannigmeier	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 492-03-C932	
17. INFORMANT Mrs. Dora Stenzel		Address Hagerstown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Atherosclerosis DUE TO Coronary Occlusion Old & Recent Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial Infarction Old & Recent DUE TO (c) Cardiac Hypertrophy INTERVAL BETWEEN ONSET AND DEATH Indefinite			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>E. W. Ditto, Jr.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.		DATE SIGNED 8-24-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/29/1960	22c. NAME OF CEMETERY OR CREMATORY St. Trinity Lutheran Cem.	22d. LOCATION (City, town, or county) (State) St. Louis, Missouri
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. Franklin Perger</i>		24a. REC'D BY REGISTRAR DATE AUG 26 '60	24b. REGISTRAR'S SIGNATURE <i>John S. Hanks</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

1
9725
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09685

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Penna.</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Rural</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Gateway Convalescent Home</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chambersburg.</u>	
		d. STREET ADDRESS <u>75x3</u>	
3. NAME OF DECEASED (Type or print) <u>David</u> First <u>Franklin</u> Middle <u>Stone</u> Last		4. DATE OF DEATH <u>Aug 6,</u> 19 <u>60</u> Month <u>6,</u> Day <u>1960</u> Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 21, 1879</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		9. AGE (In years, lost birthday) <u>80</u> yrs. IF UNDER 1 YEAR: Months <u>8</u> Days <u>15</u> Hours <u>-</u> Min. <u>-</u>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Fayetteville Penna</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>David Stone</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Zentmyer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>205-09-0417</u>	
17. INFORMANT <u>Amos D. Wenger</u> Address <u>Chambersburg Pa.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerotic Heart Dis.</u> <u>744</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Muscular Dystrophy</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4 mo</u> <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 2, 1960</u> to <u>Aug 6, 1960</u> that (I) (we) last saw the deceased alive on <u>April 5, 1960</u> and that death occurred at <u>7:30 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>David R. Brewer</u>		22b. DATE <u>8/7/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>David R. Brewer</u>		22d. ADDRESS <u>Chambersburg, Pa.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/8/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Grove</u>		23d. LOCATION (City, town, or county) (State) <u>Chambersburg, Pa.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert R. Barbour</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>	
ADDRESS <u>Chambersburg, Pa.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
DATE <u>AUG 10 '60</u>			

W. H. H. H.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

1
9693
M
081
1
0
1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09686

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Penna</u> b. COUNTY <u>Franklin</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>2 wks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greencastle</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co. Hospital</u>				d. STREET ADDRESS <u>7 South Carlisle st</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Beulah</u> Middle <u>V.</u> Last <u>Stumbaugh</u>				4. DATE OF DEATH Month <u>August</u> Day <u>14</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 26, 1893</u>	9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months <u>14</u> Days <u>14</u> Hours <u>14</u> Min.		IF UNDER 24 HRS. Months <u>14</u> Days <u>14</u> Hours <u>14</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House work</u>		11. BIRTHPLACE (State or foreign country) <u>Franklin Co. Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Russell S. Kuhn</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Wagner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>John W. Stumbaugh, Greencastle, Pa</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>199.2</u> DUE TO <u>Mixed Cell Tumor of Perotid</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>199.2</u> DUE TO <u>Mixed Cell Tumor of Perotid</u> (c) <u>199.2</u> DUE TO <u>Mixed Cell Tumor of Perotid</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 1958</u> to <u>August 1960</u> that (I) (we) last saw the deceased alive on <u>14 Aug 1960</u> and that death occurred at <u>8:15</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				22b. DATE SIGNED <u>8/15/60</u>			
22c. PHYSICIAN'S NAME (Type) <u>[Signature]</u>				22d. ADDRESS <u>[Address]</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/17/1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Franklin Co. Penna</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>				25a. REC'D BY REGISTRAR DATE <u>AUG 17 '60</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

1933

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]

1

1

9694

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09687

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. LENGTH OF STAY IN 1b <u>5 MONTHS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WESTERN MARYLAND STATE HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Sarah</u> First <u>Ann</u> Middle <u>SUMMERS</u> Last				4. DATE OF DEATH Month <u>8</u> Day <u>29</u> Year <u>1960</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JANUARY 14 - 1874</u> 86 yrs.	
9. AGE (In years last birthday) <u>86</u>				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		11. BIRTHPLACE (State or foreign country) <u>NEAR BOONSBORO WASH. CO. MD. U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>JOHN KLINE</u>			
14. MOTHER'S MAIDEN NAME <u>MAGDALENE EASTERDAY</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>NONE</u>				17. INFORMANT <u>JOHN E. SUMMERS</u> Address <u>BOONSBORO MD. R. 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobular Pneumonia, Bilateral</u> DUE TO <u>420-0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease with congestive heart failure</u> DUE TO <u>Unknown</u> (c) <u>Unknown</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary emphysema, Diabetes mellitus, Pyelonephritis.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>April 25, 1960</u> to <u>Aug. 29, 1960</u> that (I) (we) last saw the deceased alive on <u>Aug. 29, 1960</u> and that death occurred at <u>10:30 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Young E. Chun</u>				22b. DATE SIGNED <u>Aug. 29, 1960</u>			
22c. PHYSICIAN'S NAME (Type) <u>John H. East</u>				22d. ADDRESS <u>1500 Penna. Ave, Hagerstown, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>SEPT. 1, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. CARMEL CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>Mt. CARMEL WASH. Co. MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. East</u>				25a. REC'D BY REGISTRAR <u>SEP 6 '60</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles E. Hines</u>							

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9695

09688

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash.Co.Hospital</u>				d. STREET ADDRESS <u>838 Chestnut St.</u>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ANNA</u> First <u>AMELIA</u> Middle <u>TEMPLON</u> Last				4. DATE OF DEATH Month <u>August</u> Day <u>17</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 13, 1912</u>	
9. AGE (In years last birthday) <u>47</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown Wash. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Percy Rhodes</u>				14. MOTHER'S MAIDEN NAME <u>Bertha Brewer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-40-0372</u>		17. INFORMANT <u>Frank J. Templon</u> Address <u>828 Chestnut St.</u> <u>Hagerstown</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>arteriosclerosis</u> DUE TO <u>arteriosclerosis</u> (c) </div> <div style="width: 35%;"> INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>years</u> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Howard N. Weeks</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>HOWARD N. WEEKS, M.D.</u>				DATE SIGNED <u>8/19/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/20/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u> ADDRESS <u>Hagerstown, Md.</u>				24a. REC'D BY REGISTRAR <u>AUG 23 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneale</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
9696
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09689

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 02		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Maryland State Hospital		d. STREET ADDRESS 1845 Mulberry Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Gertrud Middle Luise Last Thost		4. DATE OF DEATH Month Aug. Day 1 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 10, 1877
9. AGE (In years lost birthday) 82 yrs.		IF UNDER 1 YEAR: Months 82 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Zwickau, Germany		12. CITIZEN OF WHAT COUNTRY? German	
13. FATHER'S NAME Wilhelm Sonntag		14. MOTHER'S MAIDEN NAME Lydia Grosse	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Hertha Altmann		Address Hagerstown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 450.0 IMMEDIATE CAUSE (a) Lobular pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) arteriosclerosis, general DUE TO (c) cardiac hypertrophy		INTERVAL BETWEEN ONSET AND DEATH 2 days unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 15, 1960 to Aug. 1, 1960 , that (I) (we) last saw the deceased alive on Aug. 1, 1960 , and that death occurred at 5:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Victor L. Ramos, M.D.		22b. DATE SIGNED Aug. 2, 1960	
22c. PHYSICIAN'S NAME (Type) Victor L. Ramos		22d. ADDRESS Western Md. State Hospital, Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 8/3/1960	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town, or county) (State) Washington D. C.	
24. FUNERAL DIRECTOR'S SIGNATURE Suter - Rouzer Funeral Home		25a. REC'D BY REGISTRAR Aug 3 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. Fries			

CERTIFICATE OF DEATH

10030



Name of deceased: John William Smith
Age: 45 years
Sex: Male
Usual residence: 10, Victoria Road, London, W.1
Cause of death: Myocardial infarction

Date of death: 15th October 1955

Signature of Registrar

Signature of Doctor

Place of death: Home, 10, Victoria Road, London, W.1



10030

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

M

9697

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09690

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. LENGTH OF STAY IN 1b <u>10 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. CO. HOSPITAL</u>				d. STREET ADDRESS <u>Route 40A - NORTH</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>LESLIE HARBAGH VALENTINE</u>				4. DATE OF DEATH Month <u>AUGUST</u> Day <u>4</u> Year <u>1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH-16-1884</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>18</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED TOOL GRINDER - JAMISON COLD STORAGE DOOR CO. WAYNESBORO PENNA</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>WAYNESBORO PENNA</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>REUBEN VALENTINE</u>				14. MOTHER'S MAIDEN NAME <u>MARY STULL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>214-09-9756</u>			
17. INFORMANT <u>MRS. MARY VALENTINE</u>				Address <u>BOONSBORO MD. R. 1</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Haemorrhage</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u> <u>10 days</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>July 26</u> <u>1960</u> to <u>Aug 4</u> <u>1960</u> , that (I) (we) last saw the deceased alive on <u>Aug 4</u> <u>1960</u> , and that death occurred at <u>11:40 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>G. W. He Van</u>				22b. DATE SIGNED <u>Aug 4</u>			
22c. PHYSICIAN'S NAME (Type) <u>G. W. He Van</u>				22d. ADDRESS <u>Boonsboro Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>AUG-7-1960</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>BEAVER CREEK CEMETERY</u>				23d. LOCATION (City, town, or county) (State) <u>BEAVER CREEK WASH. CO. MD.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Bast</u>				25a. REC'D BY REGISTRAR DATE <u>AUG 10 '60</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

00000

CERTIFICATE OF DEATH

1914

1

W. H. ALKIND, M.D., DEPARTMENT OF HEALTH
CITY OF NEW YORK
I, the undersigned, being a duly qualified physician, and being duly sworn, depose and say that the within and foregoing is a true and correct statement of the facts and circumstances of the death of the person named therein, and that the same was caused by the disease or injury therein stated, and that the death occurred on the day and at the place therein stated, and that the person named therein was at the time of death a resident of the city and county of New York, and that the death was not caused by any contagious, infectious, or zoonotic disease, and that the death was not caused by any criminal act or omission, and that the death was not caused by any other cause than that stated therein.

W. H. ALKIND, M.D.
DEPARTMENT OF HEALTH
CITY OF NEW YORK

1914

1

CERTIFICATE OF DEATH

Reg. Dist. No.

9698

09691

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Western Md. State Hospital #2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>NORENE</u> Middle <u>TATE</u> Last <u>WALKER</u>		4. DATE OF DEATH Month <u>AUG</u> Day <u>30</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 18, 1911</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	9. AGE (In years last birthday) <u>49</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>—</u>	
13. FATHER'S NAME <u>John Burnett</u>		14. MOTHER'S MAIDEN NAME <u>Lena Turner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>214-16-7194</u>	
17. INFORMANT <u>Brooksie Brown - sister</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO <u>Subacute & Chronic Pyelonephritis</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Carcinoma of Cervix</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>18 mo</u> <u>3 1/2 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute Pericarditis; Lobular Pneumonia</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug. 29, 1960</u> to <u>Aug 30, 1960</u> that I last saw the deceased alive on <u>Aug 30, 1960</u> and that death occurred at <u>9:30 PM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>I. B. Lyon</u>		ADDRESS (Street, city or town, state) <u>1800 Kearsy/Vanna Ave Hagerstown, Md.</u>	
PHYSICIAN'S NAME (Type) <u>I. B. Lyon</u>		DATE SIGNED <u>8/31/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-3-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial</u>	22d. LOCATION (City, town, or county) (State) <u>Sandy Spring, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert E. Snowden</u>		ADDRESS <u>Rockville, Md.</u>	
24a. REC'D BY REGISTRAR <u>SEP 6 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Brown</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH



[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Discernible words include:]

NAME OF DECEASED
AGE
SEX
DATE OF DEATH
PLACE OF DEATH
Cause of Death
Signature of Physician
Signature of Registrar

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
9699
M
081
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
302
09692

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 4 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last HARRY BACKER WARNER Sr				4. DATE OF DEATH Month Day Year August 8 1960 19			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 14 1890	
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant				10b. KIND OF BUSINESS OR INDUSTRY Retired			
11. BIRTHPLACE (State or foreign country) Hagerstown Wash Co Md.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME James B. Warner				14. MOTHER'S MAIDEN NAME Susan Davis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 214-09-7260			
17. INFORMANT Harry B. Warner Jr				Address 423 Summit Ave			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Cerebral Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardio Vasc. disease DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH 72 hrs. 14 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 6				20f. (City or town) (County) (State) Hagerstown Md.			
21. I certify that (I) (this hospital) attended the deceased from Jan 1 19 60 to Aug 8 19 60 , that (I) (we) last saw the deceased alive on Aug 8 19 60 and that death occurred at 11 P.M. from the causes and on the date stated above.				22a. SIGNATURE Robert P. Conrad M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 8-9-60			
22c. PHYSICIAN'S NAME (Type) Robert P. Conrad				22d. ADDRESS Hagerstown, 777d.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 8/11/60			
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery				23d. LOCATION (City, town, or county) (State) Hagerstown Wash ConMd.			
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				ADDRESS Hagerstown Md.			
25a. REC'D BY REGISTRAR AUG 15 '60				25b. REGISTRAR'S SIGNATURE Arthur S. Hines			

1930

(M)

Married
Hagerstown
4 Days
Hagerstown
443 Surin Ave
Hagerstown

Married
Hagerstown
443 Surin Ave
Hagerstown
March 11 1930
Hagerstown

Married
Hagerstown
443 Surin Ave
Hagerstown
March 11 1930
Hagerstown

Married
Hagerstown
443 Surin Ave
Hagerstown
March 11 1930
Hagerstown

Married
Hagerstown
443 Surin Ave
Hagerstown
March 11 1930
Hagerstown

Married
Hagerstown
443 Surin Ave
Hagerstown
March 11 1930
Hagerstown

Married
Hagerstown
443 Surin Ave
Hagerstown
March 11 1930
Hagerstown

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

1
9700
M
081
1
2
1
2081342XV3 Wm. G. Hawk

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09693

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARK Middle ELWOOD Last WILHIDE				4. DATE OF DEATH Month August Day 24 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 23, 1960	
9. AGE (In years last birthday) yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. 19 27		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant				10b. KIND OF BUSINESS OR INDUSTRY None			
11. BIRTHPLACE (State or foreign country) Hagerstown, Md.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Donald Elwood Wilhide				14. MOTHER'S MAIDEN NAME Gail Lee Silvernail			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None			
17. INFORMANT Mr. D. E. Wilhide Address 229 Woodpoint Ave. Hagerstown, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Atelectasis 762.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Multiple Congenital Deformities				INTERVAL BETWEEN ONSET AND DEATH 12 hours			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none			
20c. TIME OF INJURY Month, Day, Year Hour a. m. none 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Aug. 23, 1960 to Aug. 24, 1960 , that (I) (we) last saw the deceased alive on Aug. 23, 1960 and that death occurred at 6:30 AM , from the causes and on the date stated above.							
22a. SIGNATURE John D. Turco M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 8-25-60							
22c. PHYSICIAN'S NAME (Type) Dr. John D. Turco				22d. ADDRESS 302 N. Potomac Street - Hagerstown, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/25/60		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel ADDRESS Hagerstown, Md.				25a. REC'D BY REGISTRAR DATE AUG 26 60		25b. REGISTRAR'S SIGNATURE Arthur S. Hawk	

0000

0070

STATE OF TEXAS
 DEPARTMENT OF HEALTH
 BUREAU OF VITAL STATISTICS
 CERTIFICATE OF DEATH

Washington County Hospital	Washington County Hospital
Robertson	Robertson
Infant	Infant
Female	Female
White	White
Age 24	Age 24
Married	Married
Occupation	Occupation
Residence	Residence
Place of Birth	Place of Birth
Parents	Parents
Education	Education
Religion	Religion
Marital Status	Marital Status
Previous Illnesses	Previous Illnesses
Cause of Death	Cause of Death
Immediate Cause	Immediate Cause
Underlying Cause	Underlying Cause
Manner of Death	Manner of Death
Time of Death	Time of Death
Place of Death	Place of Death
Signature of Physician	Signature of Physician
Signature of Registrar	Signature of Registrar
Official Seal	Official Seal

9701

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09694

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Martin Manor Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First NETTIE Middle BARBARA Last WOLFE				4. DATE OF DEATH Month August Day 9 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 6, 1869	
9. AGE (In years last birthday) 91 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk				10b. KIND OF BUSINESS OR INDUSTRY Dept. Store		11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland	
13. FATHER'S NAME David Wolfe				14. MOTHER'S MAIDEN NAME Rachael Hawthorne			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-14-6420		17. INFORMANT Mrs. Carlotta Keller Address Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Brain Syndrome DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 5 yrs 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-9-1959 to 8-9-1960 that (I) too last saw the deceased alive on 8-9-1960 , and that death occurred at 5:30 AM , from the causes and on the date stated above.							
22a. SIGNATURE Dalton M. Welty				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dalton M. Welty, M.D.				22d. ADDRESS 998 Potomac Ave., Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/11/1960		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Suter - Rouzer Funeral Home R. Franklin Rouzer				ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE AUG 11 '60	
				25b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

M

090

I

0

100

2

20

1994-1995 [12-150]

110

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

9726

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 Film G271 9-15-60 et

09695

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hancock Maryland</u>		c. LENGTH OF STAY IN lb <u>5 Yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hancock Maryland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Home</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Franklin</u> Middle <u>Stuart</u> Last <u>Wood</u>				4. DATE OF DEATH Month <u>8</u> Day <u>30</u> Year <u>1960</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5.19.1907</u>	
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months <u>53</u> Days <u>53</u> Hours <u>53</u> Min. <u>53</u>		IF UNDER 24 HRS. Months <u>53</u> Days <u>53</u> Hours <u>53</u> Min. <u>53</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Narragansett R.I.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George W Wood</u>				14. MOTHER'S MAIDEN NAME <u>Delia Schmidt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes</u> <u>War War 11</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Joseph Wood 116 Moore St. Princeton N.J.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Atherosclerosis, Severe</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Coronary Thrombosis</u> (c) <u>Coronary Thrombosis</u> DUE TO (a) <u>Coronary Thrombosis</u> (b) <u>Coronary Thrombosis</u> (c) <u>Coronary Thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Recent</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>19</u> o. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Dr. E. W. Ditto, Jr.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>9-2-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9.7.60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National VA</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hancock J. Hancock</u>				ADDRESS <u>Hancock J. Hancock</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 7 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

